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In The
# Supreme Court of the United States

COLONIAL LIFE & ACCIDENT INSURANCE CO.,

*Petitioner,*

v.

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, IN THEIR OFFICIAL CAPACITIES AS COMMISSIONERS OF THE MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, AND CAROLYN CALDERON,

*Respondents.*

**On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The First Circuit**

## PETITION FOR WRIT OF CERTIORARI


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## QUESTION PRESENTED

Congress has recognized the importance of uniformity in the regulation of employer-sponsored ERISA benefits plans and expressly preempted state laws that may relate to such plans. 29 U.S.C. § 1144. The First Circuit Court of Appeals overturned an injunction entered by the District Court restraining a Massachusetts state agency investigation into whether short-term disability insurance coverage under an ERISA plan that includes a coverage distinction between mental and physical disabilities constitutes unlawful disability discrimination under state law. In so holding, the First Circuit ruled that the District Court was required to abstain from exercising jurisdiction over the state proceeding under *Younger v. Harris*, 401 U.S. 37 (1971), rejecting the argument that ERISA preemption was "facially conclusive" under *New Orleans Public Service, Inc. v. New Orleans*, 491 U.S. 350 (1981).

The question presented is whether, given the overwhelming Circuit Court authority that distinctions between mental and physical disabilities in insurance policies are permissible under the ADA, ERISA preemption of state statutes that may prohibit such distinctions is facially conclusive such that a federal court is not required to abstain under the *Younger* doctrine.

## PARTIES TO THE PROCEEDINGS

The petitioner is Colonial Life & Accident Insurance Company ("Colonial Life"). Colonial Life, along with UMass Memorial Health Care, Inc. ("UMass Memorial"), was a plaintiff at the District Court and an appellee at the First Circuit Court of Appeals.

The respondents are Malcom S. Medley, Martin S. Ebel, and Sunila Thomas-George, in their official capacities as Commissioners of the Massachusetts Commission Against Discrimination, the Commonwealth of Massachusetts, and Carolyn Calderon. The respondents were defendants at the District Court and appellants at the First Circuit.

## RULE 29.6 STATEMENT

Petitioner Colonial Life & Accident Insurance Company is a wholly-owned subsidiary of Unum Group, a publicly held company incorporated in the State of Delaware.

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## OPINIONS BELOW

The opinion of the United States Court of Appeals for the First Circuit, reversing the Order of the District Court, is reported at 572 F.3d 22 (1st Cir. 2009), and is reproduced at App. 1. The Opinion and Order of the United States District Court for the District of Massachusetts is reported at 584 F. Supp. 2d 368 (D.Mass. 2008), and is reproduced at App. 18 & 43.

## JURISDICTION

The First Circuit Court of Appeals entered its judgment on July 8, 2009. The petitioner filed a petition for rehearing en banc.[1] On August 31, 2009, the Court of Appeals denied the petition. App. 48. This Court has jurisdiction under 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

29 U.S.C. § 1144 (commonly referred to as Section 504 of ERISA) provides as follows:

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[1] On July 23, 2009, by first class mail, Petitioner filed the petition for rehearing en banc, which was received by the Court of Appeals on July 24, 2009, one day late. On July 24, 2009, Petitioner filed a motion requesting that the Court of Appeals accept the filing of the petition. On July 28, 2009, the Court of Appeals granted the Petitioner's motion to accept the late filing. App. 46.

> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .
>
> . . . .
>
> (d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited
>
> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States or any rule or regulation issued under any such law.

42 U.S.C. § 12112(a) (the Americans with Disabilities Act) provides:

> No covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.

42 U.S.C. § 12182(a) (the Americans with Disabilities Act) provides:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities,

> privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

Mass. Gen. Laws ch. 151B, § 4(16) provides in pertinent part:

> It shall be an unlawful practice
>
> . . . .
>
> For any employer, personally or through an agent, to dismiss from employment or refuse to hire, rehire or advance in employment or otherwise discriminate against, because of his handicap, any person alleging to be a qualified handicapped person.

Mass. Gen. Laws ch. 151B, § 5 provides, in pertinent part:

> After the filing of any complaint, the chairman of the commission shall designate one of the commissioners to make, with the assistance of the commission's staff, prompt investigation in connection therewith.
>
> If such commissioner shall determine after such investigation or preliminary hearing that probable cause exists for crediting the allegations of any complaint and no complainant or respondent has elected judicial determination of the matter, he shall immediately endeavor to eliminate the unlawful practice complained of or the violation of said clause (e) of said section thirty-two or said

sections ninety-two A, ninety-eight and ninety-eight A by conference, conciliation and persuasion. . . . In case of failure so to eliminate such practice or violation, or in advance thereof if in his judgment circumstances so warrant, he shall cause to be issued and served in the name of the commission, a written notice, together with a copy of such complaint, as the same may have been amended, requiring the person, employer, labor organization or employment agency named in such complaint, hereinafter referred to as respondent, to answer the charges of such complaint at a hearing before the commission, at a time and place to be specified in such notice. . . . If, upon all the evidence at the hearing the commission shall find that a respondent has engaged in any unlawful practice as defined in section four or violation of said clause (e) of said section thirty-two or said sections ninety-two A, ninety-eight and ninety-eight A, the commission shall state its findings of fact and shall issue and cause to be served on such respondent an order requiring such respondent to cease and desist from such unlawful practice or violation of said clause (e) of said section thirty-two or said sections ninety-two A, ninety-eight and ninety-eight A to take such affirmative action, including but not limited to, hiring, reinstatement or upgrading of employees, with or without back pay, or restoration to membership in any respondent labor organization, as, in the judgment of the commission, will effectuate

> the purposes of this chapter or of said clause (e) of said section thirty-two or said sections ninety-two A, ninety-eight and ninety-eight A, and including a requirement for report of the manner of compliance. Such cease and desist orders and orders for affirmative relief may be issued to operate prospectively. . . . In addition to any such relief, the commission shall award reasonable attorney's fees and costs to any prevailing complainant.

Mass. Gen. Laws ch. 272, § 98 provides:

> Whoever makes any distinction, discrimination or restriction on account of . . . deafness, blindness or any physical or mental disability or ancestry relative to the admission of any person to, or his treatment in any place of public accommodation, resort or amusement, as defined in section ninety-two A, or whoever aids or incites such distinction, discrimination or restriction, shall be punished by a fine of not more than twenty-five hundred dollars or by imprisonment for not more than one year, or both, and shall be liable to any person aggrieved thereby for such damages as are enumerated in section five of chapter one hundred and fifty-one B; provided, however, that such civil forfeiture shall be of an amount not less than three hundred dollars; but such person so aggrieved shall not recover against more than one person by reason of any one act of distinction, discrimination or restriction. All persons shall have the right to the full and equal accommodations, advantages, facilities

and privileges of any place of public accommodation, resort or amusement subject only to the conditions and limitations established by law and applicable to all persons. This right is recognized and declared to be a civil right.

## STATEMENT OF THE CASE

### 1. Introduction

Employers across the United States have developed benefits plans, some simple, some very extensive, to provide a wide variety of benefits to their employees. These plans can be designed to meet many different needs of employees – from protections against the difficulties that employees may face with respect to their health, well-being, and ability to work; to retirement programs; to time off from work. These plans frequently include a wide range of insurance programs, from health and dental to life and disability. They can encompass a variety of payment options, including benefits fully paid by the employer; to benefits with financial responsibility shared between the employer and the employee; to optional benefits made available to employees for purchase through group insurance programs selected by the employer. Employers have long been encouraged to offer such benefit plans and millions of employees nationally receive the benefits provided under such plans.

Congress recognized the societal value of such plans with the landmark passage of the Employee Retirement Income Security Act ("ERISA") of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). Congress also recognized that an exclusive, nationally uniform framework for regulating the administration of such employee benefit plans was essential to protect employers against the threat of conflicting or inconsistent state and local regulation. To effectuate such protection, Congress included an express preemption provision foreclosing any efforts by states to legislate or regulate in relationship to any employee benefit plan. 29 U.S.C. § 1144.

It is against this backdrop that this case and its issues are presented. Absent the preemption sought by the petitioner, a Massachusetts state agency will have the obligation to investigate a disability benefits policy purchased through an employer's plan and then have the opportunity and ability to declare that policy provisions in that plan constitute illegal disability discrimination under a single state's law. If such a finding is made, within that agency's authority is the ability to enter remedial equitable orders prohibiting the continued use of such distinctions in coverage (and the likely savings in premium dollars) in ERISA plans within the Commonwealth of Massachusetts. Such an outcome is exactly the type of conflicting state regulation that Congress sought to eliminate through its enactment of the ERISA preemption provision.

This is not to suggest that ERISA regulated plans are immune to consideration as to whether they illegally discriminate on the basis of disability or otherwise. To the contrary, ERISA plans are governed by federal anti-discrimination laws, including Title VII and most notably for the issues involved in this case, the Americans with Disabilities Act ("ADA"). Policy distinctions between mental and physical disabilities such as the one at issue here have been conclusively addressed relative to compliance with the ADA by eight of the twelve circuit courts of appeal. Those eight circuits have unanimously held that such distinctions do not violate the ADA.

Clearly, federal law does not prohibit such policy distinctions. Equally clearly, ERISA preempts any state law that would hold differently with respect to an employer's benefit plan. Accordingly, the District Court properly enjoined the Massachusetts state agency from proceeding with an unnecessary investigation because ERISA *preemption* is facially conclusive in this case. As set forth more fully below, the First Circuit's reversal of the District Court's decision resulted from its misapplication of the facially conclusive preemption exception to the abstention doctrine enunciated in *Younger*.

This Court should grant this petition for writ of *certiorari* in order to address the lower court's misapplication and the confusion and inconsistencies regarding the exception that are likely to result. More broadly, this Court's attention is critical to protect the nationally uniform administration of ERISA plans.

## 2. Statutory And Regulatory Framework

### A. ERISA And The ADA

As set forth above, in 1974, Congress passed landmark ERISA legislation, 29 U.S.C. § 1001 *et seq.*, "in order to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). The national scope of the issues underlying ERISA is comprehensively stated in the Congressional Findings and Declaration of Policy of the Act, 29 U.S.C. § 1001,

> The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operation scope and economic impact of such plans is increasingly interstate; . . . that they are affected with a national public interest; . . . that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce . . .

In light of the national scope of the Act and the interests of the employees that it seeks to protect, the law was also designed to "safeguard employers' interests by eliminating the threat of conflicting or inconsistent state and local regulation of employee

benefit plans." *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29197, 29933 (1974)). To accomplish this, ERISA expressly provides for the preemption of all state law causes of action "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

Consistent with Congress's intent to occupy the field of welfare benefit plan regulation with ERISA, "the phrase 'relate to' is given its broad common-sense meaning, such that a state law 'relates to' a benefit plan . . . if it has a connection with or reference to such a plan." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); *see also New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (hereinafter, "*Travelers*") (ERISA preempts state laws that "mandate employee benefit structures or their administration"); *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-49 (2001) (ERISA pre-empted state statute that would have dictated beneficiary).

State anti-discrimination laws – such as the Massachusetts discrimination laws at issue here[2] – are preempted by ERISA to the extent they prohibit practices that are lawful under federal law. *See Shaw*, 463 U.S. at 105; *Tompkins v. United Healthcare of*

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[2] The Massachusetts statutes at issue in this case are Mass. Gen. Laws ch. 151B, §4(16) and Mass. Gen. Laws ch. 272, §98. The text of the relevant portions of these statutes is set forth in the "Statutory Provisions Involved" section of this petition.

*New England, Inc.*, 203 F.3d 90, 96-97 (1st Cir. 2000) (ERISA does not preempt state laws to the extent the state laws are consistent with the mandates of federal law). In *Shaw*, this Court considered whether a New York state statute that prohibited discrimination in employee benefit plans on the basis of pregnancy was preempted by ERISA. The Court held that the "breadth of § 514(a)'s preemptive reach is apparent from the section's language. A law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan." *Id.* at 97. As such, this Court found that the New York statute, which "prohibit[ed] employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy . . . clearly 'relate[s] to' benefit plans," and was preempted by ERISA. *Id.*; *accord Travelers*, 514 U.S. at 647 (state laws mandating coverage beyond that required by federal law are preempted by ERISA).

State statutes are not preempted, however, to the extent they are concomitant with the provisions of federal law, specifically in this case, the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12112(a), 12182(a). If the ADA were to prohibit the policy provision at issue, then state law could also do so and preemption would not apply. Nine of the twelve federal circuit courts of appeal, however, have addressed the question of whether the ADA prohibits an insurer from offering differing benefits based on whether a disability is physical or mental, with a nearly unanimous outcome: such distinctions do not violate the

ADA. *EEOC v. Staten Is. S.B.*, 207 F.3d 144 (2d Cir. 2000) (federal law does not prohibit offering different disability benefits for mental and physical disabilities); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608-10 (3d Cir. 1998) (ADA does not require equal coverage for every type of disability); *Rogers v. Dept. of Health and Environ. Control*, 174 F.3d 431, 432 (4th Cir. 1999) (ADA does not require disability plan to provide equal benefits for mental and physical disabilities); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015-19 (6th Cir. 1997) (en banc) (ADA does not mandate equality between individuals with different disabilities); *see also EEOC v. CNA Ins. Cos.*, 96 F.3d 1039, 1043-45 (7th Cir. 1996); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-18 (9th Cir. 2000); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999). Only the Eleventh Circuit in *Johnson v. K Mart Corp.*, 273 F.3d 1035 (11th Cir. 2001), has held otherwise, but subsequently that Circuit vacated its panel finding that such policy distinctions were discriminatory and ordered rehearing en banc. An intervening bankruptcy delayed that rehearing and the appeal was eventually dismissed.

The First Circuit has not yet addressed this ADA question.

### B. Massachusetts Anti-Discrimination Statutes And The Massachusetts Commission Against Discrimination

Mass. Gen. Laws ch. 151B, § 4 and ch. 272, § 98 respectively prohibit discrimination in employment and in places of public accommodation. Claims of employment discrimination under Chapter 151B must first be brought before the Massachusetts Commission Against Discrimination (the "MCAD" or the "Commission"). Mass. Gen. Laws ch. 151B, § 9. Claims of public accommodation discrimination may also be brought before the MCAD. Mass. Gen. Laws ch. 151B, § 5.

Once a complaint has been filed, the MCAD is obligated to make an investigation to determine whether there is probable cause to believe that discrimination has occurred under state law. Mass. Gen. Laws ch. 151B, § 5. If such a preliminary investigative determination is made, the MCAD shall attempt to conciliate the matter and, failing resolution by such means, shall proceed to a public hearing to find the facts and enter a final order. *Id.* Upon a determination that the respondent has engaged in any unlawful discriminatory practice, the MCAD shall issue orders requiring the respondent to cease and desist such unlawful practice, to take such affirmative action as will remedy the unlawful practice and to report the manner of compliance. *Id.* The MCAD shall also award reasonable attorney's fees and costs to the complainant. *Id.* The MCAD may also impose civil penalties against the respondent. *Id.*

### 3. Factual And Procedural Background

The respondent, Carolyn Calderon, was an employee of UMass Memorial which established and maintained an employee benefit plan pursuant to ERISA for the purpose of providing certain of its employees with various benefits and insurances, including short-term disability coverage. One of the short-term disability coverage options made available through the UMass Memorial ERISA plan was through the appellant, Colonial Life. App. 99-102, 186. Ms. Calderon, an eligible employee, applied for and purchased short-term disability coverage through a policy issued by Colonial Life ("the Policy"). App. 99-102.

The Policy included an express exclusion for disability caused by "psychiatric or psychological conditions including but not limited to affective conditions, neuroses, anxiety, stress and adjustment reactions." App. 144-45. When Ms. Calderon submitted a claim for benefits under the Policy, claiming she was disabled due to grief reaction and panic disorder, Colonial Life denied the claim pursuant to the express exclusion in the Policy. App. 107.

Subsequently, Ms. Calderon filed a Charge of Discrimination (the "Charge") with the MCAD, claiming that the Policy exclusion for psychiatric and psychological conditions violated state laws banning disability discrimination in employment and places of

public accommodation. App. 107.[3] The MCAD commenced its investigation of the Charge. App. 107.

On January 23, 2008, the petitioner, Colonial Life, and UMass Memorial filed a complaint with the Federal District Court naming as defendants Ms. Calderon and the MCAD (through its Commissioners). App. 104-10. The complaint sought a declaratory judgment that ERISA preempted the state proceedings before the MCAD. In that proceeding, Colonial Life and UMass Memorial simultaneously moved for a preliminary injunction to prevent the MCAD from proceeding with its investigation. App. 94-98. The defendants opposed that request on the basis that the abstention doctrine established by this Court in *Younger v. Harris*, 401 U.S. 37 (1971), prohibited the Federal District Court from taking jurisdiction or interfering with the state agency proceeding.

The District Court granted the preliminary injunction request and enjoined the MCAD from further investigation of the state discrimination claims of Ms. Calderon. App. 43-45. In so ruling, the District Court rejected the defendants' *Younger* abstention argument on the basis of the facially conclusive exception to that doctrine suggested by this Court in *New Orleans Public Service, Inc. v. New Orleans*, 491

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[3] Ms. Calderon additionally claimed that the Policy exclusion violates the ADA and requested that the MCAD cross-file her Charge with the Equal Employment Opportunity Commission ("EEOC"). The EEOC claim is pending.

U.S. 350 (1981). App. 26-39. Specifically, the District Court held that *Younger* did not preclude it from exercising jurisdiction over the case because it was facially conclusive that ERISA preempted the state anti-discrimination statutes in the context of Ms. Calderon's claim with the MCAD. App. 38-39.

The defendants appealed the District Court's decision to the First Circuit Court of Appeals, which overturned the preliminary injunction and remanded the matter back to the District Court for dismissal. App. 1-17. The First Circuit reasoned that ERISA preemption was not facially conclusive because, although eight of the twelve circuits had held that the ADA does not prohibit insurers from offering different benefits for psychiatric and physical disabilities, it (the First Circuit) had not yet so held. As such, the First Circuit concluded that the scope of the ADA's protection was a "novel question of law," and reasoned that as a result, ERISA preemption was not facially conclusive and the *Younger* abstention doctrine would apply. App. 2-3.

## REASONS FOR GRANTING THE PETITION

### 1. The Court Of Appeals Misinterpreted Or Misapplied The Facially Conclusive Exception To The Abstention Doctrine And Its Ruling Undermines Congress's Intent To Create A Nationally Uniform Framework For ERISA Plans And Protect Such Plans From Conflicting State Laws.

The pivotal issue in this case is determining whether the facially conclusive preemption exception to *Younger* abstention suggested in *New Orleans Public Service, Inc. v. New Orleans*, 491 U.S. 350 (1981) ("*NOPSI*") applies. Although this Court's ultimate holding in *NOPSI* was based upon a determination that the state proceeding in that case was not judicial in nature, the Court discussed a logical exception where *Younger* abstention would not be proper if preemption was facially conclusive. *Id.* at 367. Following *NOPSI*, a number of circuits embraced the exception to *Younger* abstention for claims where preemption is facially conclusive. *See, e.g., Worldwide Moving & Storage, Inc. v. District of Columbia*, 445 F.3d 422, 426-27 (D.C. Cir. 2006); *Local Union No. 12004, United Steelworkers of Amer. v. Massachusetts*, 377 F.3d 64 (1st Cir. 2004); *Hughes v. Attorney General of Florida*, 377 F.3d 1258, 1265 (11th Cir. 2004); *GTE Mobilnet of Ohio v. Johnson*, 111 F.3d 469 (6th Cir. 1997).

In *NOPSI*, this Court gave some guidance regarding the application of the facially conclusive preemption exception, stating what will preclude

such a finding. Specifically, this Court stated that "what requires further *factual* inquiry" will not qualify as facially conclusive preemption. *NOPSI*, 491 U.S. at 367 (emphasis added). Refining *NOPSI* further, the Sixth Circuit has held that the facially conclusive preemption exception applies "where resolution of the dispute does not require the court to interpret *state* law or make factual findings." *Bunning v. Commonwealth of Kentucky*, 42 F.3d 1008, 1011 (6th Cir. 1994) (quoting *Norfolk & Western Ry. v. Public Utilities Comm'n of Ohio*, 926 F.2d 567, 573 (6th Cir. 1991) (emphasis added)). Neither this Court nor the Sixth Circuit, however, suggested that a federal court's typical responsibility of interpreting federal law where no factual dispute was present would foreclose a "facially conclusive" determination.

### A. The First Circuit Erroneously Concluded That The Facially Conclusive Exception Does Not Apply If A District Court Is Required To Interpret A Federal Statute.

In the instant case, the First Circuit interpreted the exception to suggest that what requires interpretation of *federal* law precludes facially conclusive preemption. Specifically, the First Circuit held that because it had not yet addressed the scope of the ADA relative to the differentiation in the payment of benefits for mental as opposed to physical disabilities, a novel question of law existed that precluded a finding of facially conclusive preemption. The First

Circuit further determined that this case implicated the "need to conduct a 'detailed analysis,' including resolving inter-jurisdictional differences" and therefore preemption could not be facially conclusive. App. 13.

This determination, however, exalts unnecessary form over important substance and effectively guts the facially conclusive exception. This Court could not have intended this result, particularly in such an important federal arena as ERISA uniformity.

The core of the analysis in this case is the simple black-and-white question: do mental/physical disability coverage distinctions in an ERISA plan violate the ADA? If they do not, then any interpretation of state anti-discrimination law to the contrary means quite simply that the state law is preempted. To ignore that straightforward conclusion on the basis that it is somehow not facially conclusive defies logic.

Further, if the ADA does not prohibit such distinctions, the only determination that the state agency could make that would *not* result in preemption is that the distinctions are not in violation of state law. If the parties are required to suffer the cost and inconvenience of a state investigation that can have only one result – that the distinctions are not discriminatory – it would seem that this is an ideal situation for a facially conclusive determination.

Given that the core of the analysis is an interpretation of the ADA, conducting that analysis is consistent with the expectation that a federal court,

when presented with a question regarding the interpretation of federal law, should undertake to decide that question, not use the absence of any prior decision to avoid making one now.

Unlike the First Circuit, the District Court appropriately interpreted and applied the federal statute in determining the preemption question. Not surprisingly, the District Court decided the question in the same manner as eight of the twelve circuits – that the ADA does not prohibit this differentiation. The First Circuit's holding in this case, however, effectively divests the District Court of its authority to interpret federal law. Through its holding, the First Circuit has narrowed the exception for facially conclusive preemption to the point that a district court in the First Circuit is now *required* to abstain under *Younger* if resolving the preemption question requires it to interpret a *federal* statute. This places an unwarranted limit on the authority of District Courts to interpret and apply federal law.

The First Circuit's decision further creates the anomaly that if its reasoning is followed in other circuits, district courts in circuits where the ADA issue has been decided may conclude that the facially conclusive exception applies and preemption is appropriate. Meanwhile, under the First Circuit's reasoning, district courts in circuits where the ADA issue has not been addressed by the circuit court cannot apply the facially conclusive exception and must permit the state proceeding to continue unimpeded. This will lead to the creation of interstate

inconsistencies with respect to who between the various district courts and state agencies shall interpret the federal statute at issue. Additionally, the First Circuit reasoning may very likely lead to the creation of a confusing patchwork of varying state interpretations with respect to whether an insurer is permitted to distinguish between physical and mental disabilities in an ERISA plan. Avoidance of that threat of conflicting or inconsistent state interpretations is precisely the concern that led Congress to including a preemption provision in the ERISA statute. 29 U.S.C. § 1144.

### B. That The First Circuit Has Not Decided Whether The ADA Prohibits Policy Provisions That Distinguish Between Mental And Physical Disabilities Does Not Warrant The Conclusion That The Issue Is A "Novel Question Of Law."

The First Circuit's decision that the facially conclusive exception should not apply in this case was based on its determination that the scope of ADA protection with respect to distinctions in benefits for physical and mental disabilities was a "novel question of law." App. 2. First, this is not a case where there is a novel question regarding the scope of ERISA preemption generally. As the district court correctly noted, "the issue of ERISA preemption of state laws is hardly a novel one." App. 28; 584 F. Supp. 2d 368, 376 (D. Mass. 2008) (citing *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *Alessi v. Raybestos-Manhatten, Inc.*, 451

U.S. 504, 526 (1981)). Likewise, this is also not a case where the federal court is tasked with interpreting a novel issue of state law. In fact, the only question upon which the preemption question hinges is whether the state anti-discrimination statutes upon which Ms. Calderon relies are consistent with the protections afforded Ms. Calderon under federal law, in this case the ADA.

As stated, eight of the twelve circuit courts of appeals have determined that policy distinctions between physical and mental disabilities, such as the provision as issue in this case, do not violate the ADA. *EEOC v. Staten Is. S.B.*, 207 F.3d 144 (2d Cir. 2000) (federal law does not prohibit offering different disability benefits for mental and physical disabilities); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608-10 (3d Cir. 1998) (ADA does not require equal coverage for every type of disability); *Rogers v. Dept. of Health and Environ. Control*, 174 F.3d 431, 432 (4th Cir. 1999) (ADA does not require disability plan to provide equal benefits for mental and physical disabilities); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015-19 (6th Cir. 1997) (en banc) (ADA does not mandate equality between individuals with different disabilities); *see also EEOC v. CNA Ins. Cos.*, 96 F.3d 1039, 1043-45 (7th Cir. 1996); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-18 (9th Cir. 2000); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999); *Gonzales v. Garner Food Servs., Inc.*, 89 F.3d 1523, 1530-31 (11th

Cir. 1996). *Contra Johnson v. K Mart Corp.*, 273 F.3d 1035 (11th Cir. 2001) (vacating court's finding that such policy distinctions were discriminatory and ordering rehearing en banc; intervening bankruptcy delayed rehearing and appeal was eventually dismissed).

In *Schering-Plough*, for example, the plaintiff brought suit claiming that the two-year cap applicable to disability benefits for mental disabilities, but not for physical disabilities, violated the ADA. The Third Circuit concluded that

> so long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities. The ADA does not require equal coverage for every type of disability; such a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA.

*Id.* at 608.

The Third Circuit noted that this result was consistent with the ADA's legislative history, and quoted the Senate Labor and Human Resources Committee report, which states:

> In addition, employers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, while it is permissible for an

> employer to offer insurance policies that limit coverage for certain procedures or treatments, e.g., only a specified amount per year for mental health coverage, a person who has a mental health condition may not be denied coverage for other conditions such as for a broken leg or for heart surgery because of the existence of the mental health condition. . . . All people with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

*Schering-Plough*, 145 F.3d at 610, quoting S.Rep. No. 101-16, at 29 (1989).

To the extent that the Massachusetts statutes at issue here prohibit such policy provisions those statutes mandate coverage beyond that required under federal law by the ADA, and are therefore preempted by ERISA. The First Circuit's conclusion that the scope of ADA protection in this context is a novel issue merely because it has not itself decided the issue is unsound, given the overwhelming voice of its sister circuits that have addressed the issue. Further, as discussed below, the decision has the potential to lead to the derailment of the uniform system of regulation of ERISA benefits plans.

### C. This Court Should Grant Certiorari Because The First Circuit's Decision Is Likely To Engender Considerable Conflict Among The Circuits And Is Likely To Lead To The Creation Of A Patchwork Of Inconsistent State Regulations Of ERISA Plans.

This Court should consider the far-reaching, practical effects of the First Circuit's decision in considering this petition for writ of *certiorari*. If left undisturbed, the First Circuit's decision that ERISA's preemption of state laws whose protection exceed that provided by the ADA is not facially conclusive will potentially have an impact on the availability and provision of disability insurance to employees covered by employers' ERISA plans. The practical effect of the First Circuit's decision is to leave the determination of the scope of protection afforded by the ADA to a state agency. As mentioned above, to the extent other circuits adopt the reasoning of the First Circuit, the opportunity for agencies of the various states to make this determination will depend upon whether the circuit court of appeals encompassing that state has decided the ADA issue.

An adverse decision by the state agency could mandate the provision of benefits in excess of those set forth in the Policy, the terms of which are in compliance with federal law, and thereby defeat ERISA's goal of uniformity in regulation. In the event that the MCAD finds that the Petitioner is prohibited from offering distinct levels of coverage for different

types of disabilities (undoubtedly at differing premium costs), such prohibition would impact all ERISA plans through which disability insurance benefits are offered in the Commonwealth of Massachusetts. Effectively, such a ruling would eliminate a Massachusetts employer's ability to offer an option of less expansive (and less expensive) disability benefits coverage to its employees. It has been established, however, that in those states encompassed by the Second, Third, Fourth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits, policy provisions like the one at issue here do not violate the ADA. Colonial Life, and all other insurers that offer ERISA plans in Massachusetts, however, could not offer such policies and would be forced to tailor their policies specifically for Massachusetts.

It is clear that in this case, the First Circuit has decided an important federal question regarding the interplay between ERISA preemption and the *Younger* abstention doctrine. Insofar as the First Circuit's decision limits the authority of the district courts to interpret federal statutes, the First Circuit's decision is inconsistent with the guidance this Court provided in *NOPSI* regarding application of the facially conclusive exception. At a minimum, the First Circuit decision suggests that these important questions have not been settled by this Court, and as such *certiorari* should be granted to settle these important questions of federal law.

Further, the First Circuit's holding conflicts with the Sixth Circuit decisions in *Bunning v. Commonwealth of Kentucky*, 42 F.3d 1008 (6th Cir. 1994) and *Norfolk & Western Ry. Co. v. Public Utilities Comm'n of Ohio*, 926 F.2d 567 (6th Cir. 1991), in which the Sixth Circuit decided questions of first impression in determining whether to apply the facially conclusive preemption exception. In *Bunning*, the Sixth Circuit considered whether Kentucky statutes regulating campaign finance activity were preempted by the Federal Election Campaign Act ("FECA"). 42 F.3d at 1010. The state election registry issued a subpoena, seeking access to Congressman James Bunning's poll questions, purportedly to determine whether there had been a violation of the state statutes. Congressman Bunning filed suit in the federal district court, seeking injunctive relief, which was granted. The state election registry argued that the district court should have abstained pursuant to the *Younger* doctrine. The Sixth Circuit disagreed, noting that "abstention is not required in a case presenting facially conclusive claims of federal preemption, where resolution of the dispute does not require the court to interpret state law or make factual findings." *Id.* at 1011. Unlike the First Circuit, however, the Sixth Circuit went on to fully address the question of whether the federal law (FECA) preempted Kentucky law – a question of first impression in that Circuit. *Id.* at 1011-12. The Court determined it was facially conclusive that FECA preempted the state law, and

that the District Court therefore appropriately declined to abstain under the *Younger* doctrine. *Id.* at 1012.

Likewise, in *Norfolk & Western Ry.*, the Sixth Circuit faced the question of whether *Younger* abstention was required in the face of a claim of preemption. In that case, the Sixth Circuit answered a question of first impression under the Federal Railroad Safety Act in order to determine whether it was facially conclusive that the Act preempted a state law mandating walkways and railings on railway bridges. *Id.* at 570. Invoking the doctrine of "negative preemption," and citing no controlling case law, the Sixth Circuit made a determination regarding the scope of preemption of the federal statute. The Sixth Circuit explained:

> [A]bstention is not required when "the naked question, uncomplicated by [ambiguous language]," is whether the state law on its face is preempted. *Hawaii Housing Auth. v. Midkiff*, 467 U.S. 229, 236-37 (1984). Similarly, "facially conclusive" claims of federal preemption may be sufficient to support federal jurisdiction in a case in which abstention would otherwise be appropriate under *Younger*. *NOPSI*, 109 S.Ct. at 2517. Thus, *NOPSI suggests that a federal court could hear a case to* ***interpret the preemptive federal law*** without making any factual findings.

*Id.* at 573 (emphasis added).

Accordingly, whether it be under Supreme Court Rule 10(a) (conflict between the circuits) or Rule 10(c) (unsettled federal question or decision in conflict with precedent of this Court), *certiorari* should be granted.

**2. At The Root Of The Issues In This Case Is Whether The ADA Prohibits Differentiation In Benefits Between Mental And Physical Disabilities; This Court Should Finally Decide This Question.**

As set forth above, eight circuit courts of appeals have decided that the ADA does not prohibit the differentiation of disability insurance benefits between those suffering mental disabilities from those suffering from physical disabilities. This Court, however, has never addressed nor finally resolved the question. Such a resolution would have obviated the concern expressed by the First Circuit at the root of its conclusion that preemption was not facially conclusive. Resolving that issue now will provide needed guidance on this issue. It would be appropriate for the Supreme Court to accept this case and resolve that important underlying question.

## CONCLUSION

For the reasons set forth above, the petitioner, Colonial Life & Accident Insurance Company, requests that the court grant its petition for *certiorari*.

Respectfully submitted,

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**United States Court of Appeals**
**For the First Circuit**

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Nos. 08-2332, 08-2379

COLONIAL LIFE & ACCIDENT INSURANCE CO. and UMASS MEMORIAL HEALTH CARE, INC.,

Plaintiffs-Appellees,

v.

MALCOLM S. MEDLEY, MARTIN S. EBEL, and SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the Massachusetts Commission Against Discrimination, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON,

Defendants-Appellants.

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APPEALS FROM THE
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

[Hon. F. Dennis Saylor, IV, *U.S. District Judge*]

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Before
Torruella, Tashima,* and Lipez,
*Circuit Judges*.

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* Of the Ninth Circuit, sitting by designation.

*Kenneth W. Salinger*, Assistant Attorney General, with whom *Martha Coakley*, Attorney General of Massachusetts, was on brief, for appellants Malcolm S. Medley, Martin S. Ebel, Sunila Thomas-George, and Commonwealth of Massachusetts.

*Susan Fendell*, Mental Health Legal Advisors Committee, for appellant Carolyn Calderon.

*Richard C. Van Nostrand*, with whom *Jessica H. Munyon* and Mirick, O'Connell, DeMallie & Lougee, LLP, were on brief, for appellees.

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July 8, 2009

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**TASHIMA, *Senior Circuit Judge.*** We must decide whether the district court erred in issuing a preliminary injunction against proceedings pending before the Massachusetts Commission Against Discrimination ("MCAD") on the ground that federal law preempted state law claims because the district court was required to abstain from deciding the preemption issue under the doctrine of *Younger* v. *Harris,* 401 U.S. 37, 45-47 (1971). We conclude that where, as here, the preemption determination would require the district court to resolve a novel question of law, preemption is not "facially conclusive," and, under such circumstances, the district court was required to abstain from deciding the preemption issue. We therefore reverse the preliminary injunction and remand to the district court with directions to dismiss

or stay the action so that MCAD may decide the preemption question in the first instance.[1]

## I. Background

Appellant Carolyn Calderon was previously employed by Appellee UMass Memorial Health Care, Inc. ("UMass"). As an employee, she received printed materials from UMass describing various disability benefits for which she was eligible. One such benefit was an optional short-term disability ("STD") insurance program available to employees expected to work at least twenty hours per week. Under the program, the employee paid the premium and could choose between policies offered by two companies, one of which was Appellee Colonial Life & Accident Insurance Company ("Colonial"). Neither UMass's description of benefits nor Colonial's policy contained any reference to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, although the description included a section describing an employee's right to appeal a denial of benefits, which UMass and Colonial now characterize as "the employee's rights under ERISA."

Calderon selected and purchased the STD coverage from Colonial. Colonial's STD policy contained a provision excluding coverage for "psychiatric or psychological condition[s] including but not limited to

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[1] We have jurisdiction of this appeal from the district court's grant of an interlocutory injunction under 28 U.S.C. § 1292(a)(1).

affective conditions, neuroses, anxiety, stress and adjustment reactions." When Calderon later submitted a claim for STD benefits due to major depressive disorder, panic disorder, and grief reaction, Colonial denied benefits pursuant to this exclusion.

Calderon then filed a Charge of Discrimination with MCAD. The charge alleged that, by providing STD benefits to persons with physical, but not mental, disabilities, UMass and Colonial violated state anti-discrimination law, specifically, Massachusetts General Laws ch. 151B § 4 and 272 §§ 92A, 98, and 98A, as well as the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101 *et seq.* MCAD notified UMass and Colonial of the charge and requested that each submit a written "position statement."

In response, UMass and Colonial filed this action, seeking a declaratory judgment that Calderon's state law claims were preempted by ERISA and injunctive relief barring further investigation by MCAD.[2] UMass and Colonial also moved for a preliminary injunction.

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[2] UMass and Colonial acknowledged that ERISA would not preempt Calderon's claims under the ADA. They argued, however, that if the state law claims were preempted, MCAD would lack authority to adjudicate the remaining federal claims and those claims, instead, would have to be investigated by the Equal Employment Opportunity Commission.

MCAD and Calderon filed cross-motions to dismiss for lack of jurisdiction under the *Younger* abstention doctrine. They argued that preemption could not be "facially conclusive" here, for two reasons. First, they argued that Calderon's state law claims were not subject to ERISA preemption because they also constituted federal discrimination claims under the ADA. Because the First Circuit has never addressed whether the ADA prohibits discrimination between mental disabilities and physical disabilities in the provision of STD benefits, Calderon and MCAD argued that this constituted a question of first impression; thus, that preemption could not be facially conclusive. Second, they argued that a factual dispute existed as to whether the STD plan at issue actually qualified as an employee benefits plan under ERISA, and that the existence of such a dispute required abstention under *Younger,* or, at a minimum, a factual determination by the district court.

The district court rejected both arguments and declined to abstain. It reasoned that, although the *Younger* criteria for abstention were met, it was "facially conclusive" that ERISA preempted the MCAD investigation with regard to Calderon's state anti-discrimination claims. In order to reach this conclusion, the district court first conducted its own analysis of whether Calderon's discrimination claims could succeed under the ADA, and thus survive preemption. It concluded that the ADA would not apply to Calderon's claims and, thus, they were preempted by ERISA.

The district court further concluded that no factual determination regarding the plan's ERISA status was necessary, reasoning that "factual inquiry [into the ERISA status of plaintiff's plan] is collateral to the issue presented here, and need not be conducted in federal court." The district court explained:

> At this stage of the proceedings, in deciding a motion for preliminary injunction, the Court finds only that the portion of the MCAD investigation applying state anti-discrimination law to a plan covered by ERISA is preempted. If further factual investigation before the MCAD, or future discovery in this action, reveals that the plan at issue here is in fact not covered by ERISA, the preliminary injunction will be modified accordingly.

Accordingly, the district court denied MCAD and Calderon's motions to dismiss and enjoined MCAD's investigation of Calderon's charge *pendente lite*. This timely appeal followed.

## II. "Facially Conclusive" Preemption Under *Younger*

Ordinarily, we "review the grant of a preliminary injunction for abuse of discretion." *Boston Duck Tours, LP* v. *Super Duck Tours, LLC*, 531 F.3d 1, 11 (1st Cir. 2008). However, we review de novo whether *Younger* mandates a district court's abstention. *Rio Grande Cmty. Health Ctr., Inc.* v. *Rullan*, 397 F.3d 56, 68 (1st Cir. 2005) (citing *Younger*, 401 U.S. at 45-47). If *Younger* requires abstention, "there is no discretion

to grant injunctive relief." *Colo. River Water Conservation Dist.* v. *United States,* 424 U.S. 800, 817 n.22 (1976).

**A.**

As a matter of comity, federal courts are required to abstain from enjoining ongoing state court proceedings absent extraordinary circumstances. *Younger,* 401 U.S. at 43-47 (addressing state criminal prosecutions); *New Orleans Pub. Serv., Inc.* v. *City of New Orleans* ("*NOPSI*"), 491 U.S. 350, 366-68 (1989) (extending *Younger* to civil proceedings). "Ordinarily, the *Younger* question [of abstention] must be decided before decision on the merits of the underlying claim." *Local Union No. 12004, USW* v. *Massachusetts,* 377 F.3d 64, 76 n.11 (1st Cir. 2004) (citing *Hicks* v. *Miranda,* 422 U.S. 332, 346 (1975)).

Under *Younger,* a federal court must abstain "if (1) there is an ongoing state judicial proceeding involving the federal plaintiff that (2) implicates important state interests and (3) provides an adequate opportunity for the federal plaintiff to assert his federal claims." *Id.* at 77 (citing *Middlesex County Ethics Comm.* v. *Garden State Bar Ass'n,* 457 U.S. 423 (1982)).

The district court found that the three criteria for abstention under *Younger* were met here, and we agree. The parties do not dispute two of the criteria, namely, that a state judicial proceeding was pending before MCAD, and that those proceedings provided

an adequate opportunity to raise the federal questions at issue. Under the remaining criterion, Colonial and UMass argue that the state proceedings do not implicate important state interests. We disagree – prohibiting unlawful employment discrimination is a "sufficiently important state interest" to warrant abstention. *See Ohio Civil Rights Comm'n* v. *Dayton Christian Sch., Inc.*, 477 U.S. 619, 629 (1986).

Because the three criteria of *Younger* are satisfied, abstention would be required unless an exception applies. *See Local Union No. 12004,* 377 F.3d at 77. The district court concluded it did not need to abstain because preemption was "facially conclusive," and we now turn to consideration of whether that exception was in fact applicable here.

**B.**

The Court has acknowledged that, "even assuming the state proceedings . . . are the sort to which *Younger* applies," abstention may not be appropriate "if the federal plaintiff will 'suffer irreparable injury' absent equitable relief." *NOPSI,* 491 U.S. at 366 (quoting *Younger,* 401 U.S. at 43-44). *NOPSI* further suggested that "[i]rreparable injury may possibly be established . . . by a showing that the challenged state statute is 'flagrantly and patently violative of express constitutional prohibitions.'" *Id.* (quoting *Younger,* 401 U.S. at 53-54). This suggestion, in turn, formed the basis for the Court's observation that a "facially conclusive" claim of preemption may likewise

be "sufficient to render abstention inappropriate." *Id.* at 367.

Because the Court concluded that the proceedings there at issue would not meet such a standard, it stopped short of determining whether such an exception actually existed. *Id.* That observation, however, has provided a sufficient basis for several circuits, including the First Circuit, subsequently to recognize an exception to abstention where pre-emption is "facially conclusive." *See Chaulk Servs., Inc.* v. *Mass. Comm'n Against Discrimination,* 70 F.3d 1361, 1370 (1st Cir. 1995); *Local Union No. 12004,* 377 F.3d at 78.

As is often the case with abstract legal standards, courts have largely defined the term "facially conclusive" by rejecting that which it is not. For example, the *NOPSI* Court explained that merely showing "a *substantial* claim of federal pre-emption" is not enough. 491 U.S. at 366-67 (emphasis supplied). Likewise, it noted that "[w]hat requires further factual inquiry can hardly be deemed "flagrantly" unlawful for purposes of a threshold abstention determination. *Id.* Finally, two of our sister circuits have held that questions of first impression preclude application of the "facially conclusive" exception. *See GTE Mobilnet of Ohio* v. *Johnson,* 111 F.3d 469, 478 (6th Cir. 1997); *Woodfeathers, Inc.* v. *Wash. County, Or.,* 180 F.3d 1017, 1022 (9th Cir. 1999).

Calderon and MCAD argue that these principles preclude application of the "facially conclusive"

exception here. We turn first to Calderon's argument that ERISA preemption was not facially conclusive because a question of first impression existed regarding her claims under the ADA.

**1.**

As the district court correctly noted, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983). ERISA, however, does not preempt other federal laws, such as the ADA. *See* 29 U.S.C. § 1144(d) ("[N]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States."); *Shaw*, 463 U.S. at 102-03; *Tompkins* v. *United Healthcare of New Eng., Inc.*, 203 F.3d 90, 96-97 (1st Cir. 2000). Further, because the ADA "contemplates that state laws will contribute to the overall federal enforcement regime," we have held that "state statutory claims target[ing] conduct unlawful under the ADA . . . would be exempt from ERISA preemption" as well. *Id.*

Calderon argued before the district court that her state law claims allege acts that are prohibited by the ADA, thus barring preemption. She further argued that, because the ADA's applicability to her claims presents a question of first impression in this circuit,

preemption was not facially conclusive and that abstention was required. Colonial and UMass responded by arguing that, where preemption turns on the scope of another federal law, district courts have the authority to weigh novel arguments about that scope in order to determine the scope of preemption.

We have not had occasion to decide whether the ADA prohibits as discriminatory an employer's decision to provide short-term disability benefits to individuals with physical disabilities, but not to those with mental disabilities.[3] Therefore, this constitutes a question of first impression in our circuit.

That, however, is not the question before us today. Rather, we must decide whether the district court properly delved into the question of the ADA's applicability to Calderon's claims under the strictures of the abstention doctrine as set forth in *Younger* and its progeny. The district court acknowledged the lack of controlling precedent on the question of whether the ADA applies to claims such as Calderon's, but

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[3] The district courts in this circuit are divided on the issue. *Compare Witham* v. *Brigham & Women's Hosp., Inc.*, 2001 WL 586717, at *3 (D.N.H. 2001) (holding that the ADA does not require equal benefits); *Wilson* v. *Globe Specialty Prods., Inc.*, 117 F. Supp. 2d 92, 96 (D. Mass. 2000) (same); *Conners* v. *Me. Med. Ctr.*, 42 F. Supp. 2d 34, 55 (D. Me. 1999) (same); *with Fletcher* v. *Tufts Univ.*, 367 F. Supp. 2d 99, 111 (D. Mass. 2005) (holding that the ADA prohibits discrimination between benefits for mental and physical disabilities); *Iwata* v. *Intel Corp.*, 349 F. Supp. 2d 135, 149 (D. Mass. 2004) (same); *Boots* v. *Nw. Mut. Life Ins. Co.*, 77 F. Supp. 2d 211, 220 (D.N.H. 1999) (same).

concluded that, under *Partners Healthcare Sys., Inc.* v. *Sullivan,* 497 F. Supp. 2d 29, 40 (D. Mass. 2007), it was permitted to answer that question before determining whether preemption was facially conclusive. It further concluded that, in fact, it was required to do so under *Shaw.* Thus, the district court "considered the rationale behind both positions" and determined that "the conclusion and reasoning of the court in *Wilson* [were] substantially more compelling" and made "considerable practical sense."[4]

We consider first whether *Shaw,* indeed, requires a district court to undertake such an analysis and conclude that it does not, for the simple reason that *Shaw* was a straightforward preemption case and did not address abstention under *Younger. See Shaw,* 463 U.S. 92-93. It is true that *Shaw* indicates that a district court faced with a *preemption* question must determine whether the alleged acts are prohibited by federal law. *See id.* at 95-96. *Shaw*, however, does not address the interplay between "facially conclusive" preemption and the *Younger* abstention doctrine, let alone hold that a district court's preemption inquiry must trump *Younger*'s requirements.

Indeed, the Supreme Court has already rejected such an approach to the abstention inquiry. In

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[4] Curiously, the district court conducted this analysis, and resolved it in favor of Colonial and UMass, despite that fact neither Colonial nor UMass briefed the merits of the ADA claims raised by Calderon.

*NOPSI,* the Court expressly rejected NOPSI's argument that "a district court presented with a preemption-based request for equitable relief should take a quick look at the merits; and if upon that look the claim appears substantial, the court should endeavor to resolve it." *See NOPSI,* 491 U.S. at 364-65; *see also Local Union No. 12004,* 377 F.3d at 76 n.11 ("Ordinarily, the *Younger* question must be decided before decision on the merits of the underlying claim."). Thus, while we recognize that Colonial and UMass may have stated "a substantial claim of federal preemption," such a claim is not enough to justify a federal court's intervention in an ongoing state proceeding. *NOPSI,* 491 U.S. at 366-67.

In sum, the district court's need to conduct a "detailed analysis," including resolving interjurisdictional differences, demonstrates that ERISA preemption of Calderon's state law claims was not, in fact, "facially conclusive." *See GTE Mobilnet,* 111 F.3d at 478. Therefore, we conclude that the principles set forth in *Younger* required the district court to abstain in deference to the state proceeding already underway.

The same principles of comity and federalism that proscribe the district court's jurisdiction likewise prohibit our consideration of the merits of Calderon's ADA claims in the first instance. *See id.* at 476-78. "In fact, to decide this preemption issue would require us to enter into a detailed analysis of state [and federal] law, a task in which we will not engage." *Id.* at 478.

MCAD has jurisdiction to conduct this analysis in the first instance, and must be permitted to do so.

2.

Because the existence of a question of first impression regarding the ADA's applicability to Calderon's claims precludes preemption from being facially conclusive, and requires the district court to abstain under *Younger*, we need not address whether the existence of a factual dispute as to the ERISA status of Colonial's STD plan required the district court either to make a factual determination or abstain under *Younger*. We note, however, that the record shows Calderon presented evidence sufficient to raise a factual dispute as to whether the STD plan she purchased from Colonial was governed by ERISA, or would instead find refuge in the "safe harbor" regulation under which the Secretary of Labor chose to exempt from ERISA certain group insurance programs where the employer is only minimally involved in providing the coverage. *See* 29 C.F.R. § 2510.3-1(j). We observe here only that, given the existence of this factual dispute, we see several problems with the district court's determination that preemption was "facially conclusive."

First, contrary to the district court's assertion that it did not need to resolve this question, ERISA only preempts state laws to the extent that they "relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). Thus, "[e]xpress ERISA

preemption analysis . . . involves two central questions: (1) whether the plan at issue is an 'employee benefit plan' [within ERISA] and (2) whether the cause of action 'relates to' this employee benefit plan." *Hampers* v. *W.R. Grace & Co., Inc.*, 202 F.3d 44, 49 (1st Cir. 2000) (internal quotation marks omitted). Because *Younger* prohibits a district court from addressing the merits of the parties' claims unless preemption is facially conclusive, and ERISA preemption requires that the plan at issue be covered by ERISA, the plan's ERISA status would have to be "facially conclusive." *See Local Union No. 12004*, 377 F.3d at 78. At this juncture, we have substantial doubts as to whether such was the case in this instance.

## III. Conclusion

Because we conclude that preemption cannot be facially conclusive if it requires the district court's detailed analysis of a question of first impression, we reverse the district court's entry of a preliminary injunction, and direct that it either dismiss the action or stay further proceedings until MCAD has entered a final ruling on the charges pending before it. Appellants shall recover their costs on appeal from Appellees.

**REVERSED and REMANDED with directions.**

**United States Court of Appeals**
**For the First Circuit**

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Nos. 08-2332, 08-2379

COLONIAL LIFE & ACCIDENT INSURANCE CO. and UMASS MEMORIAL HEALTH CARE, INC.,

Plaintiffs-Appellees,

v.

MALCOLM S. MEDLEY, MARTIN S. EBEL, and SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the Massachusetts Commission Against Discrimination, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON,

Defendants-Appellants.

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**JUDGMENT**
Entered: July 8, 2009

This cause came on to be heard on appeal from the United States District Court for the District of Massachusetts and was argued by counsel.

Upon consideration whereof, it is now here ordered, adjudged and decreed as follows: The judgment of the district court is reversed, and the matter is remanded for further proceedings consistent with

the opinion issued this day. Appellants shall recover their costs on appeal from the Appellees.

By the Court:

/s/ Richard Cushing Donovan, Clerk

cc: Hon. F. Dennis Saylor, Ms. Sarah Thornton, Clerk, United States District Court for the District of Massachusetts, Ms. Munyon, Ms. Fendell, Mr. Van Nostrand, Mr. Salinger & Ms. Cruz.

**UNITED STATES DISTRICT COURT**
**DISTRICT OF MASSACHUSETTS**

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| **COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.,**<br>**Plaintiffs,**<br>**v.**<br>**MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the Massachusetts Commission Against Discrimination; COMMONWEALTH OF MASSACHUSETTS; and CAROLYN CALDERON,**<br>**Defendants.** | **Civil Action No. 08-40010-FDS** |

**MEMORANDUM AND ORDER ON PLAINTIFFS' MOTION FOR JUDGMENT ON THE PLEADINGS OR MOTION FOR PRELIMINARY INJUNCTION AND DEFENDANTS' CROSS-MOTIONS TO DISMISS**

(Filed Sep. 30, 2008)

**SAYLOR, J.**

This is an action to enjoin an investigation of discrimination by a state agency on the grounds of

ERISA preemption. Plaintiff Colonial Life & Accident Insurance Company issued a short-term disability plan for employees of plaintiff UMass Memorial Health Care, Inc., as part of the latter's employee benefit package. Defendant Carolyn Calderon is a UMass Memorial employee who purchased a Colonial short-term disability plan. Defendants Malcolm S. Medley, Martin S. Ebel, and Sunila Thomas-George are Commissioners of the Massachusetts Commission Against Discrimination ("MCAD").

In 2007, Calderon submitted a claim for benefits based on short-term mental disability and was denied on the ground that the policy did not cover disability due to psychological or psychiatric conditions. She filed a discrimination claim with the MCAD in November 2006, contending that the denial of short-term disability benefits to individuals with mental disabilities is unlawful under state and federal law. The MCAD has begun an investigation of that discrimination charge.

Plaintiffs seek to enjoin the MCAD investigation on the grounds that it is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"). Defendants contend that the Court should abstain from exercising jurisdiction over plaintiffs' claim pursuant to *Younger v. Harris*, 401 U.S. 37 (1971), and should defer to the ongoing MCAD proceeding and any resulting appeal, where plaintiffs may raise ERISA preemption as a defense. For the reasons set forth below, the Court will grant plaintiffs' motion for preliminary injunction, deny

plaintiffs' motion for judgment on the pleadings, and deny defendants' cross-motions to dismiss.

## I. Background

Defendant UMass Memorial has established and maintains an employee benefit plan for the purpose of providing certain employees with various benefits, including short-term disability coverage. UMass Memorial employees may apply for and receive short-term disability insurance issued by Colonial as part of the employee benefit package. The policy issued by Colonial specifically excludes coverage for disability caused by psychiatric and psychological conditions.

Carolyn Calderon is a UMass Memorial employee who purchased short-term disability coverage from Colonial on January 1, 2007. On May 15, 2007, Calderon submitted a claim for benefits under the policy for the period from May 8, 2007 through August 1, 2007, during which she was unable to work due to disability. The cause of Calderon's disability was major depression, grief reaction, and panic disorder. By letter dated May 20, 2007, Colonial informed Calderon that it had denied her claim for benefits pursuant to the policy exclusion for psychiatric or psychological conditions.

On November 26, 2007, Calderon filed a charge of discrimination with the MCAD against both UMass Memorial and Colonial. In her complaint, Calderon claimed that, by refusing to provide short-term disability coverage for psychiatric or psychological

disabilities, plaintiffs had violated Massachusetts' anti-discrimination laws, Mass. Gen. Laws ch. 151B, § 4 and ch. 272, §§ 92A, 98, and 98A, as well as the federal Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 *et seq.* and 42 U.S.C. § 12182(b)(1)(A)(iii). On November 30, 2007, the MCAD began an investigation of Calderon's charge. That investigation remains pending.

On January 23, 2008, plaintiffs filed a complaint in this Court seeking declaratory judgment and injunctive relief. They simultaneously moved for judgment on the pleadings and for a preliminary injunction, contending that the MCAD's investigation into state law violations is preempted by ERISA. On April 1, 2008, the MCAD defendants opposed plaintiffs' motions and cross-moved to dismiss the complaint based on the *Younger* doctrine. Likewise, on April 2, defendant Calderon cross-moved to dismiss plaintiffs' complaint, arguing that ERISA preemption is inapplicable in this matter and urging the Court to abstain from assuming jurisdiction over the case pursuant to *Younger*.

## II. Analysis

Plaintiffs request that the Court (1) enjoin the MCAD from continuing its investigation of Calderon's discrimination claims and (2) declare that the applicable Massachusetts anti-discrimination laws are preempted by ERISA and, accordingly, that the MCAD does not have jurisdiction to address those

claims. It is well-settled that state agencies lack jurisdiction to enforce state laws against benefit plans if the law they seek to enforce is preempted by ERISA. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 102-04 (1983). ERISA preempts state law causes of action "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Accordingly, if the plan at issue is a plan covered by ERISA and the claim asserted relates to that plan, preemption applies and the state action may not proceed. *McMahon v. Digital Equip. Corp.*, 162 F.3d 28, 36 (1st Cir. 1998).

Defendants counter that under the *Younger* doctrine, the Court should abstain from adjudicating this action and should instead permit the MCAD to address plaintiffs' preemption arguments. *See Younger v. Harris*, 401 U.S. 37, 43 (1971). Furthermore, defendants contend that ERISA does not preempt federal anti-discrimination laws, and that, to the extent that Massachusetts' anti-discrimination laws prohibit practices that are also prohibited under federal law, state law is not preempted. *See* 29 U.S.C. § 1144(d); *Shaw*, 463 U.S. at 103.

Because the *Younger* abstention issue is dispositive here, the Court will address that issue first. *See Local Union No. 12004, United Steelworkers of Am. v. Massachusetts*, 377 F.3d 64, 76 n.11 (1st Cir. 2004) ("Ordinarily, the *Younger* question must be decided before decision on the merits of the underlying claim.").

### A. The *Younger* Doctrine

Under the principles established in *Younger v. Harris*, federal courts should not generally enjoin or otherwise interfere with certain ongoing state proceedings. 401 U.S. at 41 (citing a "national policy forbidding federal courts to stay or enjoin pending state court proceedings except under special circumstances"); *see also Ohio Civil Rights Comm'n v. Dayton Christian Sch., Inc.*, 477 U.S. 619, 629 (1986). *Younger* abstention arises from policies of comity and federalism that "counsel against the exercise of jurisdiction where particular kinds of state proceedings have already commenced." *Id.* at 626; *see also Pennzoil Co. v. Texaco, Inc.*, 481 U.S. 1, 10 (1987). The doctrine applies not only where there are ongoing proceedings in state court, but also where there are "state administrative proceedings that are quasi-judicial in character and implicate important state interests." *Maymo-Melendez v. Alvarez-Ramirez*, 364 F.3d 27, 31 (1st Cir. 2004) (citing *Dayton*, 477 U.S. at 627 n.2). Where a federal court finds *Younger* abstention applicable, the plaintiffs cause of action should be dismissed, and the plaintiff must raise its federal claims and defenses in the administrative proceedings or "in state-court judicial review of the administrative proceeding." *Dayton*, 477 U.S. at 629; *see also Huffman v. Pursue, Ltd.*, 420 U.S. 592, 605 (1975) (stating that a civil litigant can "seek review in [the Supreme Court] of any federal claim properly asserted in and rejected by state courts."); *Casa Marie, Inc., v. Superior Ct. of Puerto Rico*, 988 F.2d

252, 263 n.10 (1st Cir. 1993) (noting that a federal plaintiff in the state court will also have available "discretionary appellate review by the United States Supreme Court as a last resort").

Pursuant to the *Younger* doctrine, a federal court should abstain from exercising jurisdiction over ongoing state proceedings where three conditions are satisfied: "(1) the proceedings are judicial (as opposed to legislative) in nature; (2) they implicate important state interests; and (3) they provide an adequate opportunity to raise federal constitutional challenges." *Bettencourt v. Board of Registration in Med.*, 904 F.2d 772; 777 (1st Cir. 1990). The parties here do not dispute that the first and third conditions for *Younger* abstention have been met. There is no dispute that the MCAD proceedings at issue are judicial in nature. *See Brotherhood of Locomotive Eng'rs v. MCAD*, 695 F. Supp. 1321, 1322 (D. Mass. 1988). Likewise, the parties do not dispute that the MCAD proceedings provide an adequate opportunity to raise federal constitutional challenges. *Id.* at 1323. *See Dayton*, 477 U.S. at 629. The parties, however, vigorously dispute the second condition – namely, whether the state proceedings implicate important state interests.

When considering the magnitude of a state's interest in its administrative proceedings, a court does "not look narrowly to [the State's] interest in the *outcome* of the particular case," but looks to "the importance of the generic proceedings to the State." *New Orleans Pub. Serv., Inc., v. Council of New*

*Orleans*, 419 U.S. 350, 365 (1989) (hereafter "*NOPSI*"). The Supreme Court has recognized that prohibiting employers from engaging in unlawful discrimination is a "sufficiently important state interest" to warrant a federal court's abstention pursuant to *Younger*. *Dayton*, 477 U.S. at 628 (finding *Younger* abstention appropriate where the federal plaintiff sought to enjoin the state's administrative proceeding on the basis that the investigation of a gender discrimination complaint would violate the First Amendment's Free Exercise and Establishment clauses). However, even where the state's proceedings implicate important state interests, there are several exceptions to the application of the *Younger* doctrine, one of which plaintiffs contend applies here: the "facially conclusive" exception to the *Younger* doctrine.

### B. The "Facially Conclusive" Exception to the *Younger* Doctrine

Although the Supreme Court has found *Younger* abstention appropriate even where a federal plaintiff brings a *substantial* claim of federal preemption, it has left open the possibility that abstention may be inappropriate where the plaintiff brings a *facially conclusive* claim. *NOPSI*, 491 U.S. at 367. The First Circuit has "endorsed the existence of this 'facially conclusive' preemption exception to *Younger*." *Local Union No. 12004*, 377 F.3d at 78. The rationale behind this exception is that there is no significant state interest at issue "when it is clear that the state

tribunal is acting beyond the lawful limits of its authority." *Chaulk Servs., Inc., v. MCAD*, 70 F.3d 1361, 1370 (1st Cir. 1995). However, the somewhat divergent outcomes of the two leading First Circuit cases addressing the "facially conclusive" exception to *Younger* illustrate the complexity of this issue.

In *Chaulk Services*, the First Circuit held that abstention was inappropriate where a federal plaintiff sought to enjoin the MCAD's investigation of a gender discrimination claim that arose from conduct during a union-organizing campaign. 70 F.3d at 1370-71. The plaintiff argued that the National Labor Relations Act preempted the state action. Agreeing with plaintiff, the court noted that the argument for abstention was particularly weak. Congress anointed the NLRB as the "chief arbiter of labor disputes" and, when the MCAD gender discrimination charges were filed, there was already pending before the NLRB an unfair labor practice charge based on the same underlying facts. *Id.* at 1368-71. Allowing the MCAD complaint to go forward under those circumstances would threaten the uniformity in national labor policy that the Supreme Court sought to protect with the preemption doctrine it first announced in *San Diego Building Trades v. Garmon*, 359 U.S. 236 (1959). *Garmon* preemption requires deference to the exclusive competence of the NLRB where activity that is even arguably subject to the NLRA is at issue. *Chaulk Servs.*, 70 F.3d at 1364. Application of *Garmon* preemption principles made it "facially conclusive" or "readily apparent" that the MCAD was

"acting beyond its jurisdictional authority." *Id.* at 1370. Thus, the court held that *Younger* abstention was inappropriate. *Id.* at 1371.

In contrast, in *Local Union No. 12004*, the First Circuit noted that *Younger* abstention might be appropriate in an action brought under facts very similar to *Chaulk Services*: a supervisor filed charges of discrimination on the basis of sexual orientation with the MCAD premised on conduct that occurred during a labor dispute. 377 F.3d at 69. The First Circuit remanded the case for further proceedings on the issue of *Younger* abstention because, unlike *Chaulk Services*, no party had invoked the primary jurisdiction of the NLRB. The Court reasoned that, if the plaintiff had chosen for strategic reasons not to go to the NLRB, then the application of the *Garmon* doctrine to divest the MCAD of any jurisdiction was less definitive. *Id.* at 80. The First Circuit concluded that the plaintiff's argument for applying the "facially conclusive" exception to *Younger* abstention was weaker where the "rationale for *Garmon* preemption [was] less powerful." *Id.*

The difficulty, then, is determining when it is "facially conclusive" from the claims in the complaint that the state's action is preempted by federal law. In addition, there is some question as to how extensively the Court may inquire into the issues before it moves out of the parameters of "facially conclusive." The Supreme Court has stated that "what requires further factual inquiry can hardly be deemed 'flagrantly' unlawful for the purposes of a threshold abstention

determination." *NOPSI*, 491 U.S. at 367. Along this line of reasoning, defendants contend that unsettled questions of law must be presented to and decided by the MCAD, not by this Court.[1] *See Woodfeathers, Inc., v. Washington County*, 180 F.3d 1017, 1021-22 (9th Cir. 1999) (holding that the issue of preemption is not readily apparent where there is a question of first impression, but is readily apparent "where the state law fell under the express preemption clause" of ERISA); *Schlagler v. Phillips*, 166 F.3d 439, 443 (2d Cir. 1999) (stating that a broad interpretation of limited exceptions would "swallow the *Younger* rule"); *GTE Mobilnet of Ohio v. Johnson*, 111 F.3d 469, 478 (6th Cir. 1997) (finding the issue of preemption not "facially conclusive" where the court would have to "enter into a detailed analysis of state law" to determine if state law regulating cellular phone service was preempted by the Federal Communications Act). *But see Partners Healthcare Sys., Inc. v. Sullivan*, 497 F. Supp. 2d 29, 40 (D. Mass. 2007).

However, the issue of ERISA preemption of state laws is hardly a novel one. *See Egelhoff v. Egelhoff*,

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[1] Defendants contend that any "facially conclusive" preemption exception must be applied very narrowly. *See Hughes v. Attorney Gen. of Fla.*, 377 F.3d 1258, 1265 (11th Cir. 2004). The argument follows that if the Court broadly construes the "facially conclusive" exception, it would effectively erode *NOPSI*'s holding that *Younger* abstention is appropriate even when federal courts are faced with "substantial" claims that a state proceeding is preempted by federal law. *See NOPSI*, 491 U.S. at 364-66.

532 U.S. 141 (2001) (holding that ERISA preempts state statute revoking the designation of a spouse as beneficiary of a pension plan after a divorce); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526 (1981) (holding that ERISA preempts state statute outlawing the offsetting of pension payments by amount received in workers' compensation awards). Moreover, as noted earlier, the issue of ERISA preemption of state anti-discrimination laws was directly addressed by the Supreme Court in *Shaw v. Delta Airlines*. 463 U.S. 85 (1983) (holding that ERISA preempted part of the state's human rights law). Even if the Court were to consider this issue novel, "it must be wholly appropriate for this [C]ourt to weigh [the] arguments and to determine the scope of preemption" and of federal anti-discrimination law. *Partners Healthcare*, 497 F. Supp. 2d at 40 (stating that though abstention may be appropriate where the facts are unclear, the court must not shirk its responsibility to adjudicate claims within its jurisdiction "simply because the law is complicated or novel").

Pursuant to *Shaw*, a court must determine whether alleged employment practices are prohibited by federal law: "[i]f they are not, the state law will be superseded and the agency will lack authority to act." *Id.* at 105-06. Thus, if the Court determines that the ADA does not prohibit disability plans from discriminating between physical and mental disabilities, then Chapter 151B is preempted with respect to ERISA disability benefit plans.

### C. ERISA and the ADA

"Congress enacted ERISA in 1974 in order 'to promote the interests of employees and their beneficiaries in employee benefit plans,'" as well as to "safeguard employers' interests by 'eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" *McMahon*, 162 F.3d at 35-36 (quoting *Shaw*, 463 U.S. at 90, 99). Although ERISA expressly preempts all state laws that "relate to" employee benefit plans, 29 U.S.C. § 1144(a), the statute also explicitly prohibits "[a]lteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States," 29 U.S.C. § 1144(d). Construing these two subsections together and seizing on the warning against "impairment" of federal law, the Supreme Court has concluded that § 1144(d) exempts from preemption "provisions of state laws upon which federal laws depend for their enforcement." *Shaw*, 463 U.S. at 104. Federal law is not impaired, however, by preemption of state law prohibiting practices that are lawful under federal law. *Id.* at 103. Thus, state laws relating to ERISA plans are not preempted, in this context, to the extent that they are consistent with federal law.

Applying these principles to this matter, exemption from ERISA preemption is at least theoretically possible because the ADA is a federal law that depends on state law for its enforcement. The First Circuit has held that "the ADA, like Title VII, contemplates that state laws will contribute to the

overall federal enforcement regime." *Tompkins v. United Healthcare of New Eng., Inc.*, 203 F.3d 90, 96 (1st Cir. 2000); *see also Jorgensen v. Mass. Mut. Life Ins. Co.*, 2001 U.S. Dist. LEXIS 19579, at *23 (D. Mass. Nov. 27, 2001) ("[S]ome state law claims are exempt from ERISA preemption if they are a necessary part of a federal enforcement scheme under statutes like Title VII or the ADA."). Therefore, Mass. Gen. Laws ch. 151B is exempt from ERISA preemption if discrimination between classes of disabled persons is prohibited by the ADA. *Tompkins*, 203 F.3d at 96-97 (stating that "if the . . . state statutory claims targeted conduct [that is] unlawful under the ADA, those state claims would be exempt from ERISA preemption"). Accordingly, the Court must determine whether the ADA prohibits the discrimination alleged here.

Title III of the ADA prohibits discrimination between disabled individuals and other individuals in the provision of goods or services by any person who owns or operates a "place of public accommodation." 42 U.S.C. § 12182(a) & (b)(1)(A)(iii).[2] The First

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[2] Defendants' MCAD complaint alleges violations of "Part II" of the ADA but cites the section of the United States Code corresponding to Title III of the ADA. (Pl. Compl., Ex. 1 at 2). Section 12182(a) provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182(a).

(Continued on following page)

Circuit, unlike other circuits, has determined that a "public accommodation" under the ADA can include employee benefit plans under certain circumstances. *Tompkins*, 203 F.3d at 95 n.4 (citing *Carparts Distribution Ctr., Inc. v. Automotive Wholesalers*, 37 F.3d 12 (1st Cir. 1994) (holding that "public accommodations" can include health care plans)); *Fletcher v. Tufts University*, 367 F. Supp. 2d 99, 115 (D. Mass. 2005) (same). *Contra Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1114 (9th Cir. 2000) (limiting "public accommodations" to places); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-13 (3d Cir. 1998) (same); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1010-11 (6th Cir. 1997) (same). Moreover, the First Circuit has stated that "the discriminatory denial of benefits under a health care plan might, in some circumstances, state a claim under Title III of the ADA." *Tompkins*, 203 F.3d at 95 n.4.

Nonetheless, the First Circuit has left open the question whether Title III "is intended merely to

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Section 12182(b)(1)(A)(iii) of the ADA generally prohibits the provision of separate benefits, stating that "[i]t shall be discriminatory to provide an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals, unless such action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others." 42 U.S.C. § 12182(b)(1)(A)(iii).

provide access to whatever product or service the subject entity may offer, or is intended in addition to shape and control which products and services may be offered." *Carparts*, 37 F.3d at 19. *But see Weyer*, 198 F.3d at 1115 (stating that the Third and Sixth Circuits have "held that 'Title III does not govern the content of a long-term disability policy offered by an employer.'" (quoting *Parker*, 121 F.3d at 1012)). At least one court in this Circuit has applied Title III's prohibitions to the contents of a short-term disability plan, such as the one at issue here. *Conners v. Maine Med. Ctr.*, 42 F. Supp. 2d 34, 46 (D. Me. 1999) (finding that because "public accommodation" includes medical benefits plans, then "under the plain language of Title III, the [ADA] would extend to the substance or contents of an insurance policy").

Even assuming that the anti-discrimination prohibitions of the ADA were intended to apply to the contents of short-term disability plans, the question remains as to whether *any* provision of the ADA requires that individuals with mental disabilities receive the same benefits as individuals with physical disabilities under the same employee benefit plan. Most circuits that have addressed this issue have found conclusively that the ADA does *not* prohibit "discrimination" between different classes of disabilities. *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-18 (9th Cir. 2000) (holding that the ADA does require parity of coverage between mental and physical disabilities in case involving claims brought for violations of both Title I and III of

the ADA); *McNeil v. Time Ins. Co.*, 205 F.3d 179, 188 (5th Cir. 2000) (holding that Title III does not prohibit the offering of different goods and services to disabled persons, only denial of equal access to those goods and services); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1019 (6th Cir. 1997) (holding, in suit under Title III, that ADA does not prohibit discrimination between different types of disabilities). *See EEOC v. Staten Island Sav. Bank*, 207 F.3d 144, 148 (2d Cir. 2000) (holding that Title I of ADA does not bar entities from offering different benefits for mental disabilities than for physical ones); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101 (10th Cir. 1999) (same); *Lewis v. Kmart Corp.*, 180 F.3d 166, 170 (4th Cir. 1999) (same); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 610 (3d Cir. 1998) (same); *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996). *Contra Johnson v. K Mart Corp.*, 273 F.3d 1035 (11th Cir. 2001) (concluding that such disparity in disability coverage constitutes unlawful discrimination prohibited by Title I because it imposes a benefits limitation that is contingent on the kind of disability the former employee has), *vacated pending reh'g en banc*, 273 F.3d 1035, 1070 (11th Cir. 2001) (decision suspended as a result of the automatic stay imposed by Kmart Corp.'s bankruptcy petition).

The First Circuit has not addressed this issue. *Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 148 (D. Mass. 2004); *El-Hajj v. Fortis Benefit Ins. Co.*, 156 F. Supp. 2d 27, 32 (D. Me. 2001); *Wilson v. Globe Specialty Products, Inc.*, 117 F. Supp. 2d 92, 95 (D.

Mass. 2000) (stating that the First Circuit has neither condoned nor condemned "different benefits for different disabilities"). Within the Circuit, there is division on whether the ADA prohibits discrimination between mental and physical disabilities in employee benefit plans. *Compare Wilson*, 117 F. Supp. 2d at 96; *Conners v. Maine Med. Ctr.*, 42 F. Supp. 2d 34, 55 (D. Me. 1999); *Witham v. Brigham & Women's Hosp., Inc.*, 2001 WL 586717 (D.N.H. May 31, 2001); *with Iwata v. Intel Corporation*, 349 F. Supp. 2d 135 (D. Mass. 2004) (Young, J.) (finding that the ADA prohibits discrimination among classes of individuals with disabilities"); *Fletcher v. Tufts University*, 367 F. Supp. 2d 99 (D. Mass. 2005) (Lindsay, J.) (adopting Judge Young's reasoning in *Iwata*); *Boots v. Northwestern Mutual Life Ins. Co.*, 77 F. Supp. 2d 211 (D.N.H. 1999).

In finding that the ADA prohibits discrimination "amongst classes of the disabled," the court's opinion in *Iwata* followed the reasoning of the Eleventh Circuit in *Johnson*. 349 F. Supp. 2d at 148.[3] First, the Court recognized that remedial statutes should be given broad construction. Next, the court determined that, though Congress did not intend to prohibit discrimination between disabilities in health plans, such an intent did not exist for disability benefit plans. The court noted that the legislative history of

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[3] As noted, the opinion in *Johnson* was later vacated pending a rehearing *en banc*.

the ADA refers to health plans, not to benefit plans, and that the basis for differential coverage under health plans rested on actuarial principles, whereas under benefit plans, the basis for differential coverage lacked any such objective standard. *Id.* at 150-51. Also, the court found support for its holding in the fact that congressional action after the passage of the ADA has focused on providing parity among disabilities in coverage under *health* plans, not disability plans. *Id.* at 152-53.

A central factor in the reasoning of *Iwata* was the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), which held that Title II of the ADA required a state to place individuals with mental disabilities in community settings instead of institutions. Judge Young concluded that *Olmstead* created a "new conception of discrimination" under the ADA: not only does the ADA prohibit discrimination between the disabled and the non-disabled, but also "amongst classes of the disabled." *Id.* at 149. Moreover, the court found that the *Olmstead* decision abrogated earlier Supreme Court cases that held that the Rehabilitation Act, a statute that mirrors the ADA, does not require "that any benefit extend to one category of handicapped persons also be extended to all other categories of handicapped persons." *Iwata*, 349 F. Supp. 2d at 149 (citation omitted). The totality of the arguments, the court concluded, supported the finding that the ADA prohibits discrimination among classes of disabilities.

In contrast, the court in *Wilson* found that the ADA does not prohibit "different benefits for different disabilities." 117 F. Supp. 2d at 95. First, the Court noted that "the circuit law on the subject overwhelmingly supports this conclusion." *Id.* at 96 (citing eight circuit court cases holding that the ADA does not prohibit discrimination between different disabilities). Second, the ADA's legislative history supports such a conclusion, as the House and Senate reports state that insurance policies may limit coverage for different treatments – including setting limits for mental health coverage – as long as disabled individuals have the same access to health insurance as is generally provided by employers to their employees. Third, the language of § 504 of the Rehabilitation Act, 29 U.S.C. § 794, which parallels the ADA, and the Supreme Court's conclusion that the Rehabilitation Act does not require parity among disabilities, support the conclusion that the ADA also does not require such parity. Fourth, various attempts in Congress to pass legislation that would expressly prohibit discrimination in health insurance between individuals with mental disabilities and those with physical disabilities strongly suggest that the ADA does not currently prohibit such discrimination.

Finally, the court in *Wilson* determined that *Olmstead* did not "alter[ ] the legal landscape." *Id.* at 97. It concluded that the holding of *Olmstead* was limited to its facts: the case dealt with Title II of the ADA and the issue of reasonable accommodation by

public entities. Although a footnote in *Olmstead* noted past decisions in which the term discrimination "encompassed disparate treatment among members of the *same* protected class," the court in Wilson found the footnote had no greater significance other than rebutting the dissent. *Id.* Ultimately, the court concluded that *Olmstead* did not address the "[d]isparate treatment of different disabilities." *Id.*

After considering the rationale behind both positions, this Court finds the conclusion and reasoning of the court in *Wilson* substantially more compelling. Moreover, that conclusion makes considerable practical sense. If Congress had intended parity between mental and physical disabilities in the provision of employee benefit plans, it surely would have specified that desire more clearly, rather than rely on a tortuous inference from statutory language. *See McNeil*, 205 F.3d at 186-87. Thus, the Court concludes that the ADA does not prohibit discrimination among different disabilities in employee benefit plans.

In summary, because the Court finds that the ADA does not prohibit discrimination between mental and physical disabilities in the provision of short-term disability benefits, defendants' claims under Ch. 151B are preempted under ERISA. And because the Court finds that the issue of ERISA preemption is

"facially conclusive," *Younger* abstention does not apply.[4]

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[4] Defendants also contend that *Younger* abstention is inappropriate because the Court must engage in additional fact-finding to determine whether the state action is preempted. If an employer pays for what would otherwise be ERISA benefits out of general assets (that are not governed by ERISA) rather than out of an accumulated fund (that is subject to ERISA requirements) then state law may regulate those benefits without being subject to preemption. *See Massachusetts v. Morash*, 490 U.S. 107, 115-16 (1989). The MCAD charge here does not, on its face, establish that plaintiffs' short-term disability coverage is part of an ERISA plan. Defendants contend that additional facts are needed to determine whether there is merit to plaintiffs' contention that the charge concerns a plan covered by ERISA. Plaintiffs contend, however, that no further factual development is required in order to determine whether ERISA preemption is appropriate. Specifically, plaintiffs contend that it is an undisputed fact that Calderon purchased the short-term disability coverage at issue with her own money – meaning that UMass Memorial did not fund the Colonial short-term disability policy with general assets, which would exempt it from ERISA coverage.

The Court need not resolve this dispute to reach its conclusion, "Such factual inquiry [into the ERISA status of plaintiff's plan] is collateral to the issue presented here, and need not be conducted in federal court." *Partners Healthcare*, 497 F. Supp. 2d at 41. At this stage of the proceedings, in deciding a motion for preliminary injunction, the Court finds only that the portion of the MCAD investigation applying state anti-discrimination law to a plan covered by ERISA is preempted. *See id.* If further factual investigation before the MCAD, or future discovery in this action, reveals that the plan at issue here is in fact not covered by ERISA, the preliminary injunction will be modified accordingly. As in *Partners Healthcare*, however, the MCAD is advised to be "cognizant of

(Continued on following page)

**D. Motion for Preliminary Injunction**

The Court must weigh four factors in determining whether to issue a preliminary injunction: "(1) the likelihood of success on the merits; (2) the potential for irreparable harm if the injunction is denied; (3) the balance of relevant impositions, i.e., the hardship to the nonmovant if enjoined as contrasted with the hardship to the movant if no injunction issues; and (4) the effect (if any) of the court's ruling on the public interest." *Charlesbank Equity Fund II v. Blinds to Go, Inc.*, 370 F.3d 151, 162 (1st Cir. 2004). Though the "sine qua non of this four-part inquiry is likelihood of success on the merits," *New Comm Wireless Services, Inc., v. SprintCom, Inc.*, 287 F.3d 1, 9 (1st Cir. 2002), the Court must "weigh and measure each factor against the other factors," *Hybritech, Inc., v. Abbott Labs.*, 849 F.2d 1446, 1451 (Fed. Cir. 1988).

The Court's consideration of the four factors is relatively straightforward. As detailed above, plaintiffs have established a likelihood of success on the merits, as MCAD may not require the plan to pay benefits for short-term mental health disability. The Court finds that plaintiffs will suffer irreparable injury if the MCAD continues its investigation into a discrimination complaint when it lacks jurisdiction over the matter. The Court further finds that the

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this [C]ourt's order to cease any investigation once it concludes a plan is an ERISA plan." *Id.*

hardship to plaintiffs substantially outweighs that of the defendants. Finally, the Court concludes that the preliminary injunction will further the public's interest in maintaining cohesive and consistent regulation of ERISA plans. Accordingly, the MCAD defendants will be preliminarily enjoined from investigating or adjudicating the question whether plaintiffs' ERISA benefit plan violates Mass. Gen. Laws ch. 151B because it does not provide short-term mental health benefits to plan beneficiaries.[5]

### E. Motion for Judgment on Pleadings

As noted, the Court has concluded that it need not abstain from deciding this case on the basis of *Younger* abstention, and that Mass. Gen. Laws ch. 151B is preempted to the extent that it is being applied to an ERISA benefit plan. Nonetheless, plaintiffs' motion for judgment on the pleadings is premature as defendants have not yet answered the complaint. Fed. R. Civ. P. 12(c) allows motions for judgment on the pleadings only "[a]fter the pleadings are closed." As the First Circuit has pointed out, "The rule expressly provides that such relief can be sought only 'after the pleadings are closed.' Pleadings, of course, include an answer to the complaint." *Figueroa v. DEA*, 1993 U.S. App. LEXIS 26504, at *2 (1st Cir.

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[5] The preliminary injunction will be contingent upon the posting of a bond of $25,000 as security in accordance with the requirements of Fed. R. Civ. P. 65(c).

Oct. 12, 1993) (per curiam); *see also Karsten Mfg. Corp. v. Oshman's Sporting Goods, Inc.-Services*, 869 F. Supp. 778, 783 (D. Ariz. 1994) (finding plaintiff's motion for judgment on the pleadings premature where defendants had not yet filed an answer). Accordingly, the Court will deny plaintiffs' motion for judgment on the pleadings at this time.

## III. Conclusion

For the foregoing reasons plaintiffs' motion for judgment on the pleadings is DENIED, plaintiffs' motion for a preliminary injunction is GRANTED, and defendants' cross-motions to dismiss are DENIED.

A separate form of preliminary injunction order will be entered by the Court.

**So Ordered.**

/s/ F. Dennis Saylor
F. Dennis Saylor IV
United States District Judge

Dated: September 30, 2008

**UNITED STATES DISTRICT COURT**
**DISTRICT OF MASSACHUSETTS**

| | |
|---|---|
| **COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.,**<br>**Plaintiffs,**<br>**v.**<br>**MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the Massachusetts Commission Against Discrimination; COMMONWEALTH OF MASSACHUSETTS; and CAROLYN CALDERON,**<br>**Defendants.** | **Civil Action No. 08-40010-FDS** |

**PRELIMINARY INJUNCTION ORDER**

(Filed Sep. 30, 2008)

**SAYLOR, J.**

For good cause shown, and pursuant to Fed. R. Civ. P. 65, defendants Malcolm S. Medley, Martin S. Ebel, and Sunila Thomas-George, in their official capacities as Commissioners of the Massachusetts

Commission Against Discrimination, and the Commonwealth of Massachusetts ("Defendants") are hereby preliminarily restrained and enjoined as follows:

1. Defendants shall not investigate or adjudicate the charge of Carolyn Calderon that the short-term disability policy (No. 38598-47370) issued by Colonial Life & Accident Insurance Company pursuant to an employee benefit plan established by UMass Memorial Health Care, Inc., fails to comply with Massachusetts state law and regulations barring discrimination on the basis of handicap or disability because it does not provide mental health benefits.

2. This Order is binding upon Defendants and their agents, servants, and employees, and upon all persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise.

3. This Order shall take effect upon the posting of a bond as set forth below, and shall remain in effect until the conclusion of the trial of this matter; provided, however, that it may be dissolved or modified upon appropriate motion and a showing of good cause to this Court.

4. Plaintiff shall post a bond in the amount of $25,000 as soon as reasonably practicable after entry of this Order.

**So Ordered.**

/s/ F. Dennis Saylor
F. Dennis Saylor IV
United States District Judge

Dated: September 30, 2008, 4:45 p.m., at Worcester, MA

**United States Court of Appeals**
**For the First Circuit**

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No. 08-2332

COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY; UMASS MEMORIAL HEALTH CARE, INC

Plaintiffs-Appellees

v.

MALCOLM S. MEDLEY, Commissioner of the Massachusetts Commission Against Discrimination; MARTIN S. EBEL, Commissioner of the Massachusetts Commission Against Discrimination; SUNILA THOMAS-GEORGE, Commissioner; COMMONWEALTH OF MASSACHUSETTS

Defendants-Appellants

CAROLYN CALDERON

Defendant

---

No. 08-2379

COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY; UMASS MEMORIAL HEALTH CARE INC

Plaintiffs-Appellees

v.

CAROLYN CALDERON

Defendant-Appellant

MALCOLM S. MEDLEY, Commissioner of the Massachusetts Commission Against Discrimination; MARTIN S. EBEL, Commissioner of the Massachusetts Commission Against Discrimination; SUNILA THOMAS-GEORGE, Commissioner; COMMONWEALTH OF MASSACHUSETTS

Defendants

---

**ORDER OF COURT**

Entered: July 28, 2009

Appellees' motion for leave to file petition for rehearing en banc instanter is granted.

By the Court:

/s/ Richard Cushing Donovan, Clerk

cc:
Kenneth Salinger
Susan Fendell
Jessica Munyon
Richard Van Nostrand
Courtney Cruz

**United States Court of Appeals**
**For the First Circuit**

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No. 08-2332

COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY; UMASS MEMORIAL HEALTH CARE, INC

Plaintiffs-Appellees

v.

MALCOLM S. MEDLEY, Commissioner of the Massachusetts Commission Against Discrimination; MARTIN S. EBEL, Commissioner of the Massachusetts Commission Against Discrimination; SUNILA THOMAS-GEORGE, Commissioner; COMMONWEALTH OF MASSACHUSETTS

Defendants-Appellants

CAROLYN CALDERON

Defendant

---

No. 08-2379

COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY; UMASS MEMORIAL HEALTH CARE INC

Plaintiffs-Appellees

v.

CAROLYN CALDERON

Defendant-Appellant

MALCOLM S. MEDLEY, Commissioner of the Massachusetts Commission Against Discrimination; MARTIN S. EBEL, Commissioner of the Massachusetts Commission Against Discrimination; SUNILA THOMAS-GEORGE, Commissioner; COMMONWEALTH OF MASSACHUSETTS

Defendants

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Before

Lynch, *Chief Judge*,
Torruella, Boudin,
Lipez and Howard, *Circuit Judges*.

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ORDER OF COURT

Entered: August 31, 2009

Pursuant to First Circuit Internal Operating Procedure X(C), the petition for rehearing en banc has also been treated as a petition for rehearing before the original panel. The petition for rehearing having been denied by the panel of judges who decided the case and the petition for rehearing en banc having been submitted to the active judges of this court and a majority of the judges not having voted that the case be heard en banc, it is ordered that the petition

for rehearing and petition for rehearing en banc be denied.

By the Court:

/s/ Richard Cushing Donovan, Clerk

cc:
Kenneth Salinger
Susan Fendell
Jessica Munyon
Richard Van Nostrand
Courtney Cruz

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

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NO. 08-2332

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COLONIAL LIFE & ACCIDENT INSURANCE CO. AND UMASS MEMORIAL HEALTH CARE, INC.,
Plaintiffs-Appellees,

V.

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, IN THEIR OFFICIAL CAPACITIES AS COMMISSIONERS OF THE MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS,
Defendants-Appellants,

CAROLYN CALDERON,
Defendant

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NO. 08-2379

---

COLONIAL LIFE & ACCIDENT INSURANCE CO. AND UMASS MEMORIAL HEALTH CARE, INC.,
Plaintiffs-Appellees,

V.

CAROLYN CALDERON,
Defendant-Appellant

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, IN THEIR OFFICIAL CAPACITIES AS COMMISSIONERS OF THE MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS,
Defendants

July 23, 2009

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ON APPEAL FROM A PRELIMINARY INJUNCTION ENTERED BY THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

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**MOTION REQUESTING THAT THE COURT ACCEPT THE APPELLEES' FILING OF THEIR PETITION FOR REHEARING EN BANC**

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Jessica H. Munyon, Esq.
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The Appellees, Colonial Life & Accident Ins. Co. and UMass Memorial Health Care, Inc., respectfully request that this court accept the filing of their petition for rehearing *en banc*. In support of this motion, the Appellees state that ten (10) copies of the petition for rehearing *en banc*, including one copy on computer disc, were sent to the court via first class mail, postmarked July 23, 2009. The petition was received by the Court today, July 24, 2009. I am informed that the deadline for receipt, as opposed to postmark, of the petition was July 23, 2009. The Appellees state that this deadline was missed as a result of inadvertent confusion regarding the rules for the filing of briefs, as opposed to other petitions and requests with the Court. The Appellees further state that no prejudice will result from this Court's accepting for filing the petition for rehearing *en banc*.

WHEREFORE, Colonial Life & Accident Ins. Co. and UMass memorial Health Care, Inc., respectfully request that this Court accept the filing of their petition for rehearing *en banc*.

Respectfully submitted,

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, AND UMASS MEMORIAL HEALTH CARE, INC.

By their attorneys,

/s/ J Munyon
Richard C. Van Nostrand, Esq.
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Fax: (508) 791-8502

Dated: July 24, 2009

CERTIFICATE OF SERVICE

I hereby certify that on July 24, 2009, this motion was filed via facsimile with the court, and served via first class mail on Kenneth W. Salinger, Esq., Massachusetts Attorney General's Office, One Ashburton Place, Boston, MA 02108 and Susan Fendell, Esq., Senior Attorney, Mental Health Legal Advisors Committee, 399 Washington St., 4th Floor, Boston, MA 02108.

MIRICK O'CONNELL

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July 23, 2009

**BY FACSIMILE AND FIRST CLASS MAIL**

Adam Sparrow, Case Manager
United States Court of Appeals
for the First Circuit
John Joseph Moakley U.S. Courthouse
1 Courthouse Way, Suite 2500
Boston, MA 02210

Re: Colonial Life & Accident Insurance Co., et al., Plaintiffs-Appellees v. Malcolm S. Medley, et al., Defendants-Appellants
U.S. Court of Appeals for the First Circuit, Docket Nos.: 08-2332 & 08-2379

Dear Mr. Sparrow:

Enclosed please find Colonial Life & Accident Insurance Co. and UMass Memorial Health Care, Inc.'s Motion Requesting that the Court Accept the

Appellees' Filing of Their Petition for Rehearing En Banc.

Thank you.

Very truly yours,

/s/ Jessica Munyon
Jessica H. Munyon

JHM/cll
Enclosure
cc: Susan D. Fendell, Esq.
Kenneth W. Salinger, Esq.
Richard C. Van Nostrand, Esq.

---

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UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

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NO. 08-2332

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COLONIAL LIFE & ACCIDENT INSURANCE CO. AND UMASS MEMORIAL HEALTH CARE, INC.,
Plaintiffs-Appellees,

V.

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, IN THEIR OFFICIAL CAPACITIES AS COMMISSIONERS OF THE MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS,
Defendants-Appellants,

CAROLYN CALDERON,
Defendant

---

NO. 08-2379

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COLONIAL LIFE & ACCIDENT INSURANCE CO. AND UMASS MEMORIAL HEALTH CARE, INC.,
Plaintiffs-Appellees,

V.

CAROLYN CALDERON,
Defendant-Appellant

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, IN THEIR OFFICIAL CAPACITIES AS COMMISSIONERS OF THE MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS,
Defendants

July 22, 2009

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ON APPEAL FROM A PRELIMINARY INJUCTION ENTERED BY THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

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# PETITION FOR REHEARING EN BANC FOR THE PLAINTIFFS-APPELLEES

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## STATEMENT UNDER FED. R. APP. P. 35(b)(1)

Pursuant to Fed. R. App. P. 35(b), the Petitioner-Appellees, Colonial Life & Accident Ins. Co. and

UMass Memorial Health Care, Inc., respectfully petition this Court to rehear *en banc* the panel's decision in this case, which addresses distinctions in disability insurance benefits for physical and mental disabilities.

The Petitioner-Appellees seek *en banc* review because this case involves the following specific question of exceptional importance: Whether, under the abstention doctrine enunciated in *Younger v. Harris,* cite, a federal district court is precluded from determining whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts certain state anti-discrimination law claims; claims that run directly contrary to the general purposes of ERISA and the express preemption provisions of 29 U.S.C. §1144(a). The panel determined that because the scope of protection provided by the Americans with Disabilities Act ("ADA") had not yet been decided by this Circuit, the facially conclusive preemption exception to the abstention doctrine cannot apply.

In that regard, the panel decision conflicts with the following decisions of the Sixth Circuit Court of Appeals: *Norfolk & Western Railway Co. v. Public Utilities Comm'n of Ohio*, 926 F.2d 567 (6th Cir. 1991) and *Bunning v. Commonwealth of Kentucky,* 42 F.3d 1008 (6th Cir. 1994).

## STATEMENT OF THE CASE

1. *Factual Background.* UMass Memorial is a health care institution and Central Massachusetts'

largest employer. A. 7, at ¶17. UMass Memorial established and maintained an employee benefit plan (the "Plan") pursuant to ERISA for the purpose, among others, of providing certain employees with various benefits and insurances, including short-term disability coverage. A. 71-72, at §§3-4.

Carolyn Calderon, an eligible employee of UMass Memorial, applied for and received short-term disability coverage through Policy No. 3 8598-473 70 issued by Colonial on January 1, 2007 ("the Policy"). A. 72, at ¶7; A. 73, at ¶3; A. 11-32. The Policy has an express exclusion for disability caused by "a psychiatric or psychological condition including but not limited to affective conditions, neuroses, anxiety, stress and adjustment reactions." A. 24.

On or about May 15, 2007, Ms. Calderon submitted a claim for benefits under the Policy, claiming she was disabled and unable to work from May 8, 2007, through August 1, 2007. A. 74, at ¶¶4-5. According to the claim, Ms. Calderon's primary disabling condition was a psychiatric or psychological condition, specifically grief reaction and panic disorder, and her claim for disability benefits was denied pursuant to the express exclusion in the Policy. A. 74, at ¶6.

On or about November 26, 2007, Ms. Calderon filed a Charge of Discrimination (the "Charge") with the MCAD, alleging that the Policy exclusion for psychiatric and psychological conditions violated the prohibitions against discrimination on the basis of

handicap in employment (Mass. Gen. laws, ch. 151B, §4) and places of public accommodation (Mass. Gen. Laws, ch. 272, §§92A, 98 and 98A). A. 37. Ms. Calderon additionally claims that the Policy exclusion violates the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, et seq. A. 37.

The MCAD initiated its investigation by issuing notice to UMass Memorial and Colonial of the filing of the Charge and the requirement that each submit a Position Statement responding to the allegations of discrimination. UMass Memorial and Colonial filed their Position Statements on January 23, 2008, and simultaneously filed a Complaint with the District Court, seeking injunctive relief. A. 6-10.

2. *Prior Proceedings.* In their complaint, Colonial and UMass Memorial named as defendants the three MCAD Commissioners in their official capacities, Ms. Calderon, and the Commonwealth of Massachusetts. A. 2, 7. Colonial and UMass Memorial sought a preliminary injunction, to prevent the MCAD from investigating, adjudicating, or otherwise proceeding with Ms. Calderon's Charge of Discrimination, on the grounds that her claims are preempted by ERISA. A. 10, 63, 67. Colonial and UMass Memorial simultaneously filed a motion for judgment on the pleadings. A. 63.

The MCAD defendants and Ms. Calderon filed separate cross-motions to dismiss on grounds of *Younger* abstention. A. 3, 75-78. The MCAD and Ms. Calderon also each filed oppositions to UMass

Memorial and Colonial's motions for injunctive relief and for judgment on the pleadings. A. 3.

On September 30, 2008, the district court denied the defendants' motions to dismiss, and issued the requested injunctive relief. A. 4; Add. 19. At that time, the court denied the plaintiffs' motion for judgment on the pleadings, because the defendants had not yet answered the complaint. Add. 18-19.

On October 16, 2008, the MCAD defendants and Ms. Calderon filed notices of appeal from the preliminary injunction and from the denial of their cross-motions to dismiss. A. 4; Add. 87-90. On July 8, 2009, this Court reversed the District Court, holding that the District Court should have abstained from deciding the preemption issue. As the basis for that decision, the panel held that making the determination that the state law claims were preempted required the District Court to decide an issue of federal statutory interpretation relative to the ADA and this Circuit had not yet spoken on that issue.

## ARGUMENT

### I. *Younger* Abstention Does Not Preclude The District Court From Interpreting Federal Law.

"It is emphatically the province and duty of the judicial department to say what the law is." *Marbury v. Madison,* 5 U.S. 137, 177 (1803). The panel's holding in this case is inconsistent with this basic principle.

The pivotal issue in this case is determining whether the "facially conclusive preemption" exception to *Younger* abstention applies. The Supreme Court has stated that "what requires further *factual* inquiry" does not qualify as facially conclusive preemption. *New Orleans Public Service, Inc. v. New Orleans,* 491 U.S. 350, 367 (1981) ("*NOPSI*") (emphasis added). Likewise, the Sixth Circuit Court of Appeals has held that the facially conclusive preemption exception applies "where resolution of the dispute does not require the court to interpret *state* law or make factual findings." *Bunning v. Commonwealth of Kentucky,* 42 F.3d 1008, 1011 (6th Cir. 1994) (quoting *Norfolk & Western Ry. V. Public Utilities Comm'n of Ohio,* 926 F.2d 567, 573 (6th Cir. 1991) (emphasis added)).

Through its holding, the panel has narrowed the exception for facially conclusive preemption to the point that a District Court in this Circuit is now required to abstain under *Younger* if resolving the preemption question requires the court to interpret a *federal* statute. This places an unnecessary limit on the authority of District Courts in this circuit to state what the law is.

This is not a case where there is a novel question regarding the scope of ERISA preemption generally. This is also not a case where the federal court is tasked with interpreting a novel issue of state law. In this case, the question is the scope of protection provided by a federal statute, specifically the ADA.

As the district court correctly noted, "the issue of ERISA preemption of state laws is hardly a novel one." 548 F.Supp.2d 368, 376 (D. Mass. 2008) (citing *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001); *Alessi v. Raybestos-Manhatten, Inc.,* 451 U.S. 504, 526 (1981)). More to the point, the Supreme Court of the United States has determined that ERISA preempts state anti-discrimination laws, such as the state statutes relied upon by Ms. Calderon. *Shaw v. Delta Air Lines,* 463 U.S. 85, 108 (1983). The only question then, is whether the state anti-discrimination laws upon which Ms. Calderon relies are consistent with the protections afforded Ms. Calderon under federal law, in this case the ADA. Although the First Circuit has not spoken on that precise issue, many Circuit Courts of Appeal have; furthermore, as illustrated by the decisions summarized in Section II, a federal district court is certainly the proper forum for resolution of such an issue.

## II. The Panel's Decision Relative To The Facially Conclusive Exception To The *Younger* Abstention Doctrine Is Inconsistent With Decisions Of The Sixth Circuit Court of Appeals.

The panel's holding in this case is that the facially conclusive preemption exception to *Younger* abstention does not apply where resolution of the preemption question requires the district court to make a determination regarding the interpretation of a federal statute, and the controlling circuit court has not spoken regarding the interpretation of the federal

statute. This holding is inconsistent with the following Sixth Circuit decisions:

a. *Bunning v. Commonwealth of Kentucky*, 42 F.3d 1008 (6th Cir. 1994).

In *Bunning*, the Sixth Circuit considered whether Kentucky statutes regulating campaign finance activity were preempted by the Federal Election Campaign Act ("FECA"). 42 F.3d at 1010. The state election registry issued a subpoena, seeking access to certain of Congressman James Bunning's poll questions, purportedly to determine whether there had been a violation of the state statutes. Congressman Bunning filed suit in the federal district court, seeking injunctive relief, which was granted. The state election registry argued that the district court should have abstained pursuant to the *Younger* doctrine.

The Sixth Circuit disagreed, noting that "abstention is not required in a case presenting facially conclusive claims of federal preemption, where resolution of the dispute does not require the court to interpret state law or make factual findings." *Id.* at 1011. The Sixth Circuit then went on to fully address the question of whether the FECA preempted Kentucky law – which was a question of first impression in the Circuit. *Id.* at 1011-1012. The Court determined it was facially conclusive that the FECA preempted the state law, and that the District Court therefore appropriately declined to abstain under the *Younger* doctrine. *Id.* at 1012.

b. *Norfolk & Western Ry. Co. v. Public Utilities Comm'n of Ohio,* 926 F.2d 567 (6th Cir 1991).

In *Norfolk & Western Ry.,* the Sixth Circuit also faced the question of whether *Younger* abstention was required in the face of a claim of preemption. In that case, the Sixth Circuit answered a question of first impression in order to determine whether it was facially conclusive that the Federal Railroad Safety Act preempted a state law mandating walkways and railings on railway bridges. *Id.* at 570. Invoking the doctrine of "negative preemption," and citing no controlling case law, the Sixth Circuit made a determination regarding the scope of preemption of the federal statute. The Sixth Circuit explained:

> [A]bstention is not required when "the naked question, uncomplicated by [ambiguous language]," is whether the state law on its face is preempted. *Hawaii Housing Auth. V. Midkiff,* 467 U.S. 229, 236-37 (1984). Similarly, "facially conclusive" claims of federal preemption may be sufficient to support federal jurisdiction in a case in which abstention would otherwise be appropriate under *Younger. NOPSI,* 109 S.Ct. at 2517. Thus, *NOPSI suggests that a federal court could hear a case to* ***interpret the preemptive federal law*** without making any factual findings.

*Id.* at 573 (emphasis added).

## III. The Practical Effect Of The Panel's Decision Is Contrary To The Express Purpose Of ERISA.

In 1974, the United States Congress passed ERISA "in order to promote the interests of employees and their beneficiaries in employee benefit plans." *McMahon v. Digital Equip. Corp.*, 162 F.3d 28, 35 (1st Cir. 1998) (*quoting Shaw*, 463 U.S. 85, 90 (1983)). The national scope of the issues underlying ERISA is comprehensively stated in the Congressional Findings and Declaration of Policy of the Act, 29 U.S.C. §1001,

> The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operation scope and economic impact of such plans is increasingly interstate; . . . that they are affected with a national public interest; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce . . .

In light of the national scope of the act and the interests of the employees that it seeks to protect, the law was also designed to "safeguard employers' interests by *eliminating the threat of conflicting or*

*inconsistent state and local regulation of employee benefit plans." Id.* at 36 (emphasis added); *Shaw,* 463 U.S. at 99 (quoting 120 Cong. Rec. 29197, 29933 (1974)).

The practical effect of this panel's holding, however, will be just that: inconsistent state and local regulation. In the event that the MCAD determines that the ADA prohibits an insurer from offering distinct levels of coverage for different types of disabilities, such prohibition would impact all ERISA plans offered in the Commonwealth of Massachusetts. Colonial Life, and all other insurers that offer ERISA plans in Massachusetts, will have to tailor separate policies specifically to comply with the law of Massachusetts. It has been established, however, that in those states encompassed by the Second, Third, Fourth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits, policy provisions like the one at issue here do not violate the ADA. *EEOC v. Staten Is. S.B.,* 207 F.3d 144 (2d Cir. 2000) (federal law does not prohibit offering different disability benefits for mental and physical disabilities); *Ford v. Schering-Plough Corp.,* 145 F.3d 601, 608-10 (3d Cir. 1998) (ADA does not require equal coverage for every type of disability); *Rogers v. Dept. of Health and Environ. Control,* 174 F.3d 431, 432 (4th Cir. 1999) (ADA does not require disability plan to provide equal benefits for mental and physical disabilities); *Parker v. Metro. Life Ins. Co.,* 121 F.3d 1006, 1015-19 (6th Cir. 1997) (en banc) (ADA does not mandate equality between individuals with different disabilities); *see also EEOC*

*v. CNA Ins. Cos.*, 96 F.3d 1039, 1043-45 (7th Cir. 1996); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-18 (9th Cir. 2000); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999).[1] This patchwork of inconsistent state laws is precisely the scenario ERISA is intended to avoid.

Furthermore, such a result would have far-reaching implications in the insurance industry. The decision will eventually effectively require insurers to broadly cover mental health disabilities which are presently excluded. The elimination of that exclusion will undoubtedly have a negative impact on ERISA plans in the form of increased premiums. It will almost certainly result in employers reevaluating disability coverage for its employees in their ERISA plans.

This broad, industry-wide impact could not have been intended by Congress in enacting the ADA. As the Third Circuit put it in *Schering-Plough*, "The ADA does not require equal coverage for every type of disability; such a requirement, if it existed, would destabilize the insurance industry in a manner

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[1] The only Circuit that has held otherwise, the Eleventh Circuit in *Johnson v. K Mart Corp.*, 273 F.3d 1035 (11th Cir. 2001), vacated its finding that such policy distinctions were discriminatory and ordered rehearing *en banc*. An intervening bankruptcy delayed that rehearing and the appeal was eventually dismissed.

definitely not intended by Congress when passing the ADA." 145 F.3d 601, 608.[2]

## CONCLUSION

For the foregoing reasons, Colonial Life & Accident Insurance Co. and UMass Memorial Health Care, Inc. request that their petition for rehearing *en banc* be granted.

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[2] In fact, that Congress did not intend such a sweeping impact on the insurance industry is also supported by a review of the ADA's legislative history. The Senate Labor and Human Resources Committee report states: "[E]mployers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, while it is *permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, e'g', only a specified amount per year for mental health coverage,* a person who has a mental health condition may not be denied coverage for other conditions. . . ." *Schering-Plough,* 145 F.3d at 610, *quoting* S.Rep. No. 101-116, at 29 (1989) (emphasis added).

Likewise, the "legislative history subsequent to the ADA's passage evinces that Congress did not believe the ADA mandated parity between mental and physical disability benefits. In 1996, the Senate defeated an amendment to the Health Insurance Portability and Accountability Act of 1996 . . . which would have mandated, parity in insurance coverage. . . . Such an amendment would have been unnecessary altogether if the ADA already required such parity." *Id.*

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.

Plaintiffs

V.

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON.

Defendants

CIVIL NO. 08-CV-40010-FDS

PLAINTIFFS' REPLY TO OPPOSITION OF THE DEFENDANTS TO MOTION FOR JUDGMENT ON THE PLEADINGS

(Filed Apr. 29, 2008)

This Memorandum is submitted by the plaintiffs, Colonial Life & Accident Insurance Company ("Colonial") and UMass Memorial Health Care, Inc. ("UMass Memorial") (collectively, "Plaintiffs"), in reply to the opposition memoranda submitted by the defendants, Malcolm S. Medley, Martin S. Ebel and Sunila Thomas-George ("MCAD Defendants") and Carolyn

Calderon ("Ms. Calderon") (collectively, "Defendants") to the Plaintiffs' Motion for Judgment on the Pleadings.

The thrust of the Complaint filed by the Plaintiffs was that the investigation undertaken by the MCAD Defendants in response to the Charge of Discrimination filed by Ms. Calderon is preempted by the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq. ("ERISA"). Because the Plaintiffs believe that there are no facts in dispute and that the preemption issue can be decided as a matter of law, the plaintiffs have moved for judgment on the pleadings in that regard. In opposition, the defendants have asserted arguments based upon: (1) the *Younger* abstention doctrine; (2) that preemption does not apply; (3) that ERISA does not preempt the Americans with Disabilities Act, 42 U.S.C. § 12112(a) ("ADA"); (4) that the ADA prohibits the discrimination alleged by Ms. Calderon; and (5) that the Plaintiffs' Motion is premature or procedurally defective. The first two and the fourth of those issues are extensively briefed in the Plaintiffs' Memorandum in Opposition to Defendants' Cross-Motions to Dismiss and the original Memorandum in Support of Plaintiffs' Motion for Judgment on the Pleadings, arguments that will not be restated here.

This Memorandum is therefore submitted in response to the third argument that ERISA does not preempt the ADA (made by Ms. Calderon) and the fifth argument that the Plaintiffs' Motion is premature or procedurally defective.

The thrust of the argument made by Ms. Calderon is that this Court should not enjoin the MCAD Defendants from their investigation and adjudication because the MCAD investigation encompasses Ms. Calderon's claims under both Massachusetts discrimination law, G.L. c. 151B, and under the ADA. This argument is misplaced.

Massachusetts is a "deferral" state. The Equal Employment Opportunity Commission ("EEOC") is permitted to defer to a state agency such as the MCAD for investigation of potential violations of employment discrimination law where there is a state law prohibiting the unlawful employment practice alleged and establishing or authorizing a state to grant or seek relief from such practice. 42 U.S.C. §2003e-5(c). In conducting its investigation, the MCAD determines whether probable cause exists to believe that discrimination in violation of state law has occurred and, if so, then proceed to an adjudication as to whether the discrimination is proven.

The MCAD has no similar adjudicatory function under federal law. The EEOC may accord substantial weight to final findings and orders made by the MCAD in determining whether reasonable cause exists to believe that the allegation of discrimination is true. 42 U.S.C. §2003e-5(b). If the EEOC makes the determination that discrimination may have occurred under federal law, the EEOC may attempt to obtain a conciliation agreement from the discriminator and, if unsuccessful, pursue enforcement of that claim judicially. 42 U.S.C. §2003e-5(f)(1). The EEOC may also

elect not to proceed and may issue a right to sue letter for the victim to pursue the claim judicially. 42 U.S.C. §2003e-5(f)(1)(A).

If this Court were to grant the requested injunctive relief, it would preclude the MCAD from investigating the *state* discrimination claims asserted by Ms. Calderon. It would not preclude the EEOC from conducting any investigation of claims under the ADA. The Plaintiffs therefore make no argument that the potential claims of Ms. Calderon under the ADA are preempted.

The MCAD Defendants also make the limited argument that the Motion for Judgment on the Pleadings should be denied an the basis that it is "procedurally defective." Memorandum in Support of MCAD Defendants' Cross-Motion to Dismiss on the Basis of *Younger* Abstention and in Opposition to Plaintiffs' Motions for Judgment on the Pleadings and for Preliminary Injunction ("MCAD Defendants' Memorandum"), p. 17-18. The basis for this argument is that the MCAD Defendants have not yet filed an Answer to the Plaintiffs' Complaint. This argument exalts form over substance in this case where the facts are not in dispute and resolution is dependent upon matters of law only.

For the argument of the MCAD Defendants to have any merit, the Answer, once filed, would have to raise factual issues not appropriately resolved by a Motion for Judgment on the Pleadings. In their Opposition, the MCAD Defendants assert that "factual

findings are needed to determine whether there is merit to plaintiffs' allegation that the Charge concerns an ERISA plan." MCAD Defendants' Memorandum, p. 17. In support of that statement, the MCAD Defendants cite to a footnote in the Plaintiffs' Memorandum regarding "funding for the benefits under the plan," and that "proof of this assertion is a necessary part of plaintiffs' ERISA preemption defense." The MCAD Defendants further state that "[i]f an employer pays for what would otherwise be ERISA benefits out of general assets (which are not governed by ERISA) rather than out of an accumulated fund (which is subject to ERISA requirements), then state law may regulate those benefits without being preempted by ERISA," (citation omitted). *Ibid.* This need for factual inquiry identified by the MCAD Defendants, however, is moot in light of the undisputed fact that Ms. Calderon purchased the short-term disability coverage at issue with her own funds. *See*, Defendant Calderon's Memorandum in Support of Defendant Calderon's Cross-Motion to Dismiss and in Opposition to Plaintiffs' Motions for Judgment on the Pleadings, Preliminary and Permanent Injunctions, pp. 1 ("the subject of Ms, Calderon's claim was the short-term disability policy which was part of UMass Memorial's employee benefit package and which she purchased from Colonial") and 2 ("part of the benefits offered by UMass Memorial to its employees is short-term disability insurance . . . Ms. Calderon purchased the plaintiffs' short-term disability insurance coverage").

No further factual development is therefore necessary and the Plaintiffs' Motion for Judgment on the Pleadings is ripe for this Court's determination.

## CONCLUSION

For the reasons stated in the plaintiffs' original Memorandum and as supplemented by the arguments set forth herein, the Plaintiffs' Motion for Judgment on the Pleadings should be granted.

Respectfully submitted,

UMASS MEMORIAL
HEALTH CARE, AND
COLONIAL LIFE & ACCIDENT
INSURANCE COMPANY

By their attorneys,

/s/ Richard C. Van Nostrand
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Jessica H. Munyon, Esq.
BBO #658729
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100 Front Street
Worcester, MA 01608-1477
Phone: (508) 791-8500
Fax: (508) 791-8502

Dated: April 29, 2008

CERTIFICATE OF SERVICE

I, Richard C. Van Nostrand, hereby certify that this document(s), filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on April 29, 2008.

/s/ Richard C. Van Nostrand
Richard C. Van Nostrand, Esq.

Dated: April 29, 2008

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

COLONIAL LIFE &
ACCIDENT INSURANCE
CO., et al.

Plaintiffs,

v.

MALCOLM MEDLEY, et al.

Defendants

CIVIL ACTION NO.
4-08-CV40010

**DEFENDANT CALDERON'S CROSS-MOTION TO DISMISS**

(Filed Apr. 2, 2008)

Defendant Carolyn Calderon respectfully moves to dismiss this action without prejudice under Fed. R. Civ. P. 12(b)(6) on the grounds that the Court must abstain from exercising jurisdiction over the Plaintiffs' claims pursuant to *Younger v. Harris,* 401 U.S. 37 (1971) and its progeny. The grounds for this motion are set forth in Defendant Calderon's Memorandum In Support of Defendant Calderon's Cross-Motion to Dismiss and In Opposition to Plaintiffs' Motions for Judgment on the Pleadings, Preliminary and Permanent Injunctions.

**Certification of Compliance with L.R. 7.1(A)(2)**

The undersigned counsel hereby certifies that she has conferred with Plaintiffs' counsel and that we have attempted in good faith to resolve or narrow the issue presented by this motion.

Dated: April 2, 2008

Respectfully submitted,
Carolyn Calderon,
by her Attorney,

/s/ Susan Fendell

Susan Fendell
(BBO#548283)
Mental Health Legal
Advisors Committee
399 Washington Street,
4th Floor
Boston, MA 02108
617-338-2345 ext. 29

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Certificate of Service

I hereby certify that this document was filed through the Electronic Case Filing (ECF) system and thus copies will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF); paper copies will be sent to those indicated on the NEF as non registered participants on or before April 2, 2008.

/s/ Susan Fendell

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

COLONIAL LIFE &
ACCIDENT INSURANCE
CO., et al.

Plaintiffs,

v.

MALCOLM MEDLEY, et al.

Defendants

CIVIL ACTION NO.
4-08-CV40010

**DEFENDANT CALDERON'S MEMORANDUM IN SUPPORT OF DEFENDANT CALDERON'S CROSS-MOTION TO DISMISS and IN OPPOSITION TO PLAINTIFFS' MOTIONS FOR JUDGMENT ON THE PLEADINGS, PRELIMINARY AND PERMANENT INJUNCTIONS**

(Filed Apr. 2, 2008)

## I. *Introduction*

Defendant, Carolyn Calderon, filed charges of discrimination under Mass. Gen. Laws c. 151B, §4 and c. 272, §§92A, 98 and 98A and the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 et seq., against Plaintiffs, colonial Life & Accident Insurance Company ("Colonial") and UMass Memorial Health Care, Inc. ("UMass Memorial") with the Massachusetts Commission Against Discrimination ("MCAD"). The subject of Ms. Calderon's claim was the short term disability policy which was part of

UMass Memorial's employee benefit package and which she purchased from Colonial. The policy discriminates against persons with mental disabilities in that, on its face, persons with mental disabilities are denied benefit payments although they meet all other eligibility requirements of the policy.

* * *

EXHIBIT 1

**plication to: Colonial Life & Accident Insurance Company** — **PO Box 1365 Columbia, SC 29202**

**pplicant Section**

| pplicant's Name (First, MI, Last) | | Gender | Birthdate (mm/dd/yyyy) | Social Security No. |
|---|---|---|---|---|
| AROLYN CALDERON | Employee ☒<br>Spouse ☐<br>Dependent ☐ | M ☐<br>F ☒ | [Date Of Birth Omitted] | [Social Security Number Omitted] |

| ome Address – Street City State Zip Code | State of Birth | Employee ID/Payroll No. |
|---|---|---|
| [Home Address Omitted] | NJ | |

| ate Employed | Occupation/Job Title | Hrs. Worked/Week | Annual Base Salary | |
|---|---|---|---|---|
| 08/19/2000 | ADMISSION | 40 | 31,200.00 | Home Phone No. 508-888-9163<br>Business Phone No. 508-334-8753<br>508-856-2244 |

**illing Section**

| ayroll Deduction Employer Name | Employer Address (Street-City-State-Zip) | Section/Dept. No. | Employee Class |
|---|---|---|---|
| MASS Memorial Health Care [Illegible] | 15 Belmont St<br>Worcester, MA 01605-2650 | | |

| ayer or Owner if other than Applicant (Name, Address, Social Security No.) | ☐ Payer ☐ Owner ☒ Both |
|---|---|

**pouse and Dependent Section**

| ame of Spouse (First, MI, Last) | Gender M ☐ F ☐ | Birthdate (mm/dd/yyyy) | Relationship | Social Security No. |
|---|---|---|---|---|
| nployer's Name for Spouse | Date Employed | Occupation/Job Title | Hours Worked/Week | Annual Base Salary |
| Are there any eligible dependent children applying for coverage? | | | Yes ☐ No ☐ | Number Deps: |

| omplete Question 2 for all Products | Applicant | Spouse |
|---|---|---|
| A. Are you actively working? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| B. If "No", is your spouse disabled or unable to work? | [redacted] | Yes ☐ No ☐ |

**an Section**

| Indicate Type of Change (N) New (T) Transfer or (R) Rider Addition. Indicate Tax Status (P) for pre-tax (A) for after tax | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Product | Type Coverage | Type of Change | Policy Plan Code | Units/ Amount | Rider Plan/ Units | Rider Plan/ Units | Rider Plan Code | Rider Plan Code | Tax Status | Monthly Premium |
| ☐ Accident | | | | | | | | | P ☐ A ☐ | |
| ☐ Hospital Confinement | | | | | | | | | P ☐ A ☐ | |
| ☐ Cancer | | | | | | | | | P ☐ A ☐ | |
| ☐ Int. Care | | | | | | | | | P ☐ A ☐ | |
| ☐ Critical Illness | | | | | | | | | P ☐ A ☐ | |
| ☒ Disability | Elim/Benefit Period 0/7 6 months | N | DSNP | 17.0000 | | | | | P ☐ A ☒ | 62.90 |
| | | | | | | | | | **Total Monthly Premium $** | **62.90** |

| Replacement Section -Complete for all Products | | | |
|---|---|---|---|
| 3. Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? If yes, provide details. | | | Yes ☐ No ☒ |
| Insured's Name | Insurance Company | Type of Coverage | Policy Number |
| | | | |

| AIDS Section - Complete for all Products | Applicant | Spouse | Dependent |
|---|---|---|---|
| 4. Have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)? | Yes ☐ No ☒ | Yes ☐ No ☐ | Yes ☐ No ☐ |

| Simplified Issue Section - Disability and Hospital Confinement | Applicant | Spouse |
|---|---|---|
| 5. Have you previously purchased disability coverage that will remain in force which, when combined with | Yes ☐ | Yes ☐ |

| | | |
|---|---|---|
| the coverage you are applying for; will exceed 70% of your gross annual income? This does not include employer paid group disability coverage. | No ☒ | No ☐ |
| 6. Within the past 12 months, other than colds, flu or normal pregnancy, have you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle? | Yes ☐<br>No ☒ | Yes ☐<br>No ☐ |
| 7. Within the past 12 months, have you received medical advice or sought treatment (including medication) for:<br>Heart Attack (MI), Heart Surgery, Congestive Heart Failure, Stroke, Transient Ischemic Attack; Blood Pressure Reading of 160/100 or Above, Kidney Disease except Stones, Insulin Dependent Diabetes, Diabetes Diagnosed Prior to Age 40, Cancer Other than Skin Cancer; Hepatitis B, C, Cirrhosis, Hodgkin's Disease, Leukemia | Yes ☐<br>No ☒ | Yes ☐<br>No ☐ |

| **Dependent Health Section - Hospital Confinement** | |
|---|---|
| 8. Within the past 12 months, has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? If yes, provide details. **Any dependent listed will not be covered under the Hospital Confinement policy to which a copy of the application is attached.** | Yes ☐<br>No ☐ |

| Name (First, MI, Last) | Relationship | Birthdate (mm/dd/yyyy) | Social Security No. |
|---|---|---|---|
| | | | |

## EXHIBIT 2

## COLONIAL LIFE & ACCIDENT INSURANCE COMPANY POLICY SCHEDULE

NAMED INSURED CAROLYN CALDERON

BILLING CONTROL NUMBER E-745232-9

POLICY NUMBER 3 8598-473 70

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

THIS POLICY PROVIDES THOSE BENEFITS SHOWN IN THE POLICY SCHEDULE BELOW

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

EFFECTIVE DATE OF COVERAGE 01-01-2007

TOTAL MONTHLY PREMIUM $62.88

| ACCIDENT | ON-JOB | OFF-JOB |
|---|---|---|
| TOTAL DISABILITY BENEFIT | | |
| BENEFIT PERIOD: | | |
| 6 MONTHS | | |
| ELIMINATION PERIOD: | | |
| 0 DAYS | NO | |
| MONTHLY BENEFIT AMOUNT | BENEFIT | $1700.00 |

SICKNESS

| | | |
|---|---|---|
| TOTAL DISABILITY BENEFIT | | |
| BENEFIT PERIOD: | | |
| 6 MONTHS | | |
| ELIMINATION PERIOD: | | |
| 7 DAYS | NO | |
| MONTHLY BENEFIT AMOUNT | BENEFIT | $1700.00 |

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.

Plaintiffs,

V.

MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, and CAROLYN CALDERON,

Defendants.

Civil Action No. 08-CV-40010-FDS

**MCAD DEFENDANTS' CROSS-MOTION TO DISMISS ON THE BASIS OF *YOUNGER* ABSTENTION**

(Filed Apr. 1, 2008)

Defendants Malcolm S. Medley, Martin S. Ebel, and Sunila Thomas-George (the "MCAD Defendants") respectfully move to dismiss this action without prejudice under Fed. R. Civ. P. 12(b)(6) on the ground that

the Court must abstain from exercising jurisdiction over the Plaintiff's claims – as required by *Younger v. Harris,* 401 U.S. 37 (1971), and its progeny (so-called *Younger* abstention) – in light of the strong interest of the Commonwealth of Massachusetts in the on-going investigation by the Massachusetts Commission Against Discrimination (the "MCAD") regarding a possible violation of Massachusetts anti-discrimination laws. The grounds for this motion are set forth in the accompanying memorandum.

**Request for Oral Argument.**

Pursuant to L.R. 7.1(D), the MCAD Defendants request a hearing on this motion, on the ground that oral argument is likely to be of assistance to the Court.

**Certification of Compliance With L.R. 7.1(A)(2)**

The undersigned counsel hereby certifies that he has conferred with Plaintiffs' counsel and that we

have attempted in, good faith to resolve or narrow the issue presented by this motion.

MARTHA COAKLEY
*ATTORNEY GENERAL*
*OF MASSACHUSETTS*

/s/ Kenneth W. Salinger
Kenneth W. Salinger
(BBO # 556967)
Assistant Attorney General
Administrative Law Division
One Ashburton Place
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April 1, 2008

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Certificate of Service

I hereby certify that this document was filed through the Electronic Case Filing (ECF) system and thus copies will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF); paper copies will be sent to those indicated on the NEF as non registered participants on or before April 2, 2008.

/s/ Kenneth W. Salinger

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

| | |
|---|---|
| COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.<br>Plaintiffs<br>V.<br>MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON.<br>Defendants | CIVIL ACTION NO. |

**PLAINTIFFS' MOTION FOR JUDGMENT ON THE PLEADINGS**

Pursuant to Federal Rule of Civil Procedure 12(c), plaintiffs, Colonial Life & Accident Insurance Company ("Colonial") and UMass Memorial Health Care, Inc. ("UMass Memorial"), move this Court for

judgment on the pleadings. The law is abundantly clear that federal preemption of the state law claims should be applied and a declaratory judgment entered that the defendants, Malcolm S. Medley, Martin S. Ebel, and Sunila Thomas-George, as Commissioners of the Massachusetts Commission Against Discrimination ("MCAD"), an agency of the Commonwealth of Massachusetts, do not have jurisdiction and therefore may not take any further action to investigate or adjudicate the underlying claim brought before that agency by Carolyn Calderon ("Ms. Calderon").

Ms, Calderon has filed a Charge of Discrimination ("the Charge") with the MCAD, asserting that an exclusion found in a short term disability insurance policy purchased by her from Colonial is discriminatory and violates state law, specifically Mass. Gen. Laws, c. 151B, §4 and c. 272, §§92A, 98 and 98A. The policy was purchased by Ms. Calderon through an employee benefit plan offered by UMass Memorial to its employees, including Ms. Calderon. That plan and the policy issued by Colonial is covered by the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq ("ERISA").

As is set forth more fully in the accompanying Memorandum and Affidavits, plaintiffs move for judgment on the pleadings on the following grounds:

1. At all relevant times, Ms. Calderon was an employee of UMass Memorial.

2. UMass Memorial established and maintained an employee benefit plan pursuant' to ERISA ("the Plan") for the purpose, among others, of providing or making available to certain employees various benefits, including short term disability coverage.

3. Short term disability coverage was made available through policies issued by Colonial.

4. The short term disability coverage offered by UMass Memorial to its employees is set forth in UMass Memorial's Summary Plan Description ("SPD"). The SPD includes a section setting forth an employee's rights under ERISA, and encourages employees to acquire short term disability coverage.

5. As an employee of UMass Memorial eligible for the benefits provided by the plan, Ms. Calderon selected this benefit, and purchased short term disability coverage through a policy issued by Colonial on January 1, 2007 ("the Policy").

6. Ms. Calderon submitted a claim for benefits under the Policy. According to the claim, Ms. Calderon's primary disabling condition was a psychiatric or psychological condition, specifically depression, anxiety and panic disorder.

7. The terms of the Policy expressly exclude coverage of psychiatric or psychological conditions.

8. Colonial informed Ms. Calderon that her claim for disability benefits was denied pursuant to the Policy exclusion.

9. Ms. Calderon filed a Charge of Discrimination with the defendant, MCAD, seeking to negate the Policy exclusion and force Colonial to provide her benefits under the Policy issued under the Plan.

10. Pursuant to 29 U.S.C. §1144(a), ERISA supercedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

11. ERISA preempts the application of Mass. Gen. Laws, c. 151B and c. 272 to the Policy and therefore preempts the MCAD's consideration of Ms. Calderon's claim.

WHEREFORE, plaintiffs request that this Court grant it judgment on the pleadings, declare that ERISA preempts Ms. Calderon's claim and permanently enjoin the MCAD and its Commissioners from

any further proceedings in connection with that claim.

Respectfully submitted,

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, AND UMASS MEMORIAL HEALTH CARE

By their attorneys,

/s/ Richard C. Van Nostrand
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Fax: (508) 791-8502

Dated: January 23, 2008

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

| | |
|---|---|
| COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.<br>Plaintiffs<br>V.<br>MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON.<br>Defendants | CIVIL ACTION NO. |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

Pursuant to Federal Rule of Civil Procedure 65, plaintiffs, Colonial Life & Accident Insurance Company ("Colonial") and UMass Memorial Health Care, Inc. ("UMass Memorial"), move this Court for a preliminary injunction, restraining the defendants, Malcolm S. Medley, Martin S. Ebel, and Sunila

Thomas-George, as Commissioners of the Massachusetts Commission Against Discrimination ("MCAD"), an agency of the Commonwealth of Massachusetts, from investigating or adjudicating a claim brought by Carolyn Calderon ("Ms. Calderon") before that agency until a final judgment has been entered by the Court in this matter.

Ms. Calderon has filed a Charge of Discrimination ("the Charge") with the MCAD, asserting that an exclusion found in a short term disability insurance policy purchased by her from Colonial is discriminatory and violates state law, specifically Mass. Gen. Laws, c. 151B, §4 and c. 272, §§92A, 98 and 98A. The policy was purchased by Ms. Calderon through an employee benefit plan offered by UMass Memorial to its employees, including Ms. Calderon. That plan and the policy issued by Colonial is covered by the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq ("ERISA"). Accordingly, further investigation or processing of Ms. Calderon's state law claim by the MCAD is pre-empted by ERISA.

In this action, the plaintiffs seek a declaration that the state law claim is pre-empted by ERISA and a permanent injunction restraining the MCAD from taking any further action in connection with Ms. Calderon's Charge. The plaintiffs have moved for judgment on the pleadings as a matter of law. In the event that this Court should determine that the plaintiffs' Motion for Judgment on the Pleadings should not be granted at this time, a preliminary injunction should be granted effectively staying proceedings in the MCAD until this matter is fully

and finally heard and resolved. The denial of that preliminary injunction request will subject the parties to potentially wasteful proceedings in the agency if it is later determined that the plaintiffs' argument relative to pre-emption is correct.

As is set forth more fully in the accompanying Memorandum and Affidavits, plaintiffs move for preliminary injunctive relief on the following grounds:

1. At all relevant times, Ms. Calderon was an employee of UMass Memorial.

2. UMass Memorial established and maintained an employee benefit plan pursuant to ERISA ("the Plan") for the purpose, among others, of providing or making available to certain employees various benefits, including short term disability coverage.

3. Short term disability coverage was made available through policies issued by Colonial.

4. The short term disability coverage offered by UMass Memorial to its employees is set forth in UMass Memorial's Summary Plan Description ("SPD"). The SPD includes a section setting forth an employee's rights under ERISA, and encourages employees to acquire short term disability coverage.

5. As an employee of UMass Memorial eligible for the benefits provided by the plan, Ms. Calderon selected this benefit, and purchased short term disability coverage through a policy issued by Colonial on January 1, 2007 ("the Policy").

6. Ms. Calderon submitted a claim for benefits under the Policy. According to the claim, Ms.

Calderon's primary disabling condition was a psychiatric or psychological condition, specifically depression, anxiety and panic disorder.

7. The terms of the Policy expressly exclude coverage of psychiatric or psychological conditions.

8. Colonial informed Ms. Calderon that her claim for disability benefits was denied pursuant to the Policy exclusion.

9. Ms. Calderon filed a Charge of Discrimination with the defendant, MCAD, seeking to negate the Policy exclusion and force Colonial to provide her benefits under the Policy issued under the Plan.

10. Pursuant to 29 U.S.C. §1144(a), ERISA supercedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

11. ERISA preempts the application of Mass. Gen. Laws, c. 151B and c. 272 to the Policy and therefore preempts the MCAD's consideration of Ms. Calderon's claim.

12. The plaintiffs have a substantial likelihood of success on the merits of their preemption argument.

13. Unless the preliminary injunction is issued, the parties will be subjected to potentially wasteful proceedings.

14. Neither the agency defendants nor Ms. Calderon will suffer any harm if the preliminary injunction is granted.

15. Public policy favors the issuance of this injunction.

WHEREFORE, plaintiffs request that in the event that this Court does not grant their Motion for Judgment on the Pleadings, then a preliminary injunction should be issued, enjoining the MCAD and the state official defendants from any further investigation or proceedings with respect to the claim of Ms. Calderon.

Respectfully submitted,

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, AND UMASS MEMORIAL HEALTH CARE, INC.

By their attorneys,

/s/ Richard C. Van Nostrand
Richard C. Van Nostrand, Esq.
BBO #507900
Jessica H. Munyon, Esq.
BBO #658729
Mirick, O'Connell, DeMallie & Lougee, LLP
100 Front Street
Worcester, MA 01608-1477
Phone: (508) 791-8500
Fax: (508) 791-8502

Dated: January 23, 2008

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

| | |
|---|---|
| COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.<br>Plaintiffs<br>V.<br>MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON.<br>Defendants | CIVIL ACTION NO. |

**AFFIDAVIT OF SHARON DISALVO**

I, Sharon DiSalvo, do hereby under oath depose and state the following:

1. I am Senior Director, Benefits & HRIS at UMass Memorial Health Care, Inc. ("UMass Memorial").

2. UMass Memorial has established and maintains an employee benefit plan for its employees.

3. As part of its employee benefit plan, UMass Memorial makes available to certain employees various benefits and insurances, including short term disability insurance coverage ("STD benefits"). A description of the short term disability policy is included in UMass Memorial's Summary Plan Description, a true and genuine copy of which is attached to the Complaint as Exhibit C.

4. The STD benefits are available to employees who hold a position budgeted for at least twenty (20) hours per week.

5. Eligible employees pay the premiums for STD benefits from their salary, through payroll deduction.

6. Carolyn Calderon is an employee of UMass Memorial.

7. As part of her employee benefits package as an employee of UMass Memorial, Ms. Calderon applied for and received short term disability insurance coverage through a policy issued by the Colonial Life and Accident Insurance Company.

Signed under the pains and penalties of perjury this 22nd day of January 2008.

/s/ Sharon DiSalvo
Sharon DiSalvo
Senior Director, Benefits & HRIS
UMass Memorial Health Care, Inc.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

| | |
|---|---|
| COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.<br>Plaintiffs<br>V.<br>MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON.<br>Defendants | CIVIL ACTION NO. |

**AFFIDAVIT OF MARILYNN M. SIMMONS**

I, Marilynn M. Simmons, do hereby under oath depose and state the following:

1. I am Senior Litigation Support Specialist at Colonial Life & Accident Insurance Company ("Colonial").

2. Colonial issues short term disability policies to certain employees of UMass Memorial Health

Care, Inc. ("UMass Memorial"), as part of UMass Memorial's employee benefits package.

3. As a UMass Memorial employee, Carolyn Calderon ("Ms. Calderon") applied for and received short term disability coverage through policy no. 3 8598-473 70 issued by Colonial ("the Policy"). A true and genuine copy of the Policy is attached to the Complaint as Exhibit A.

4. On or about May 15, 2007, Ms. Calderon submitted a claim for benefits under the Policy, claiming she had been disabled since May 8, 2007.

5. According to the claim, Ms. Calderon's primary disabling condition was a psychiatric or psychological condition, specifically grief reaction and panic disorder.

6. By letter dated May 20, 2007, Colonial informed Ms. Calderon that her claim for disability benefits was denied pursuant to the terms of the Policy, which expressly exclude coverage of psychiatric or psychological conditions.

7. On our [sic] about November 26. 2007, Ms. Calderon filed a Charge of Discrimination with the Massachusetts Commission Against Discrimination, alleging that the Policy violates Mass. Gen. Laws, c. 151B and c. 272, §§92A, 98 and 98A. A true and genuine copy of the Charge as received by Colonial is attached to the Complaint as Exhibit B.

Signed under the pains and penalties of penury this 14th day of January 2008.

/s/ Marilynn M. Simmons

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

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|---|---|
| COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and UMASS MEMORIAL HEALTH CARE, INC.<br><br>Plaintiffs<br><br>V.<br><br>MALCOLM S. MEDLEY, MARTIN S. EBEL, AND SUNILA THOMAS-GEORGE, in their official capacities as Commissioners of the MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION, COMMONWEALTH OF MASSACHUSETTS, and CAROLYN CALDERON.<br><br>Defendants | CIVIL ACTION NO. |

**COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF**

## I. PARTIES

1. Plaintiff, Colonial Life & Accident Insurance Company ("Colonial"), is a corporation registered to do business in the Commonwealth of Massachusetts, with a principal place of business in Columbia, South Carolina.

2. Plaintiff, UMass Memorial Health Care, Inc. ("UMass Memorial"), is a non-profit corporation operating under the laws of the Commonwealth of Massachusetts and having a principal place of business in Worcester, Massachusetts. UMass Memorial is the product of a statutory merger between the University of Massachusetts Medical Center and Memorial Hospital in the late 1990's.

3. Defendants, Malcolm S. Medley, Martin S. Ebel, and Sunila Thomas-George are the duly appointed Commissioners of the Massachusetts Commission Against Discrimination ("MCAD"), an agency of the Commonwealth of Massachusetts, with addresses at One Ashburton Place, Boston, Ma; 455 Main St., Rm. 100, Worcester, MA; and 436 Dwight Street, Rm. 220, Springfield, MA.

4. Defendant, Carolyn Calderon ("Ms. Calderon") is an individual with an address of [Home Address Omitted], Worcester, Massachusetts. At all times relevant hereto, Ms. Calderon has been and is an employee of UMass Memorial. Ms. Calderon is named as an interested party, but plaintiffs seek no injunctive or other relief against her personally.

## II. JURISDICTION AND VENUE

5. This case presents a federal question and therefore this Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 28 U.S.C. § 2201.

6. Venue is proper in this district and section pursuant to 28 U.S.C. § 1391(c) and Local Rule 40.1(D)(1)(c).

## III. FACTS

7. UMass Memorial is the largest employer in Central Massachusetts and, upon information and belief, is the ninth largest employer in Massachusetts.

8. UMass Memorial established and maintained an employee benefit plan pursuant to the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq. ("ERISA") for the purpose, among others, of providing or making available to certain employees various benefits including short term disability coverage.

9. The short term disability coverage made available by UMass Memorial to its employees is set forth in UMass Memorial's Summary Plan Description ("SPD"). *See* SPD, a true and genuine copy of which is attached hereto as Exhibit C, at pp. 2-4.

10. Short term disability coverage is available to UMass Memorial employees through Colonial.

11. As an employee of UMass Memorial eligible for the benefits provided by the plan, Ms. Calderon purchased short term disability coverage through Policy No. 3 8598-473 70 ("the Policy") issued by Colonial on January 1, 2007. A true and genuine copy of the Policy is attached to this Complaint as Exhibit A.

12. On or about May 15, 2007, Ms. Calderon submitted a claim for benefits under the Policy, claiming she was disabled and unable to work from May 8, 2007, through August 1, 2007. Ms. Calderon has asserted that her primary disabling condition was a psychiatric or psychological condition, to wit, depression, anxiety and panic disorder.

13. The terms of the Policy, specifically on page 9 of the Section entitled "What Is Not Covered By This Policy," expressly exclude coverage of psychiatric or psychological conditions. *See* Exhibit A.

14. By letter dated May 20, 2007, Colonial informed Ms. Calderon that her claim for disability benefits was denied pursuant to the Policy exclusion.

15. On or about November 26, 2007, Ms. Calderon filed a Charge of Discrimination with the MCAD ("the Charge"), alleging that the Policy violates Mass. Gen. Laws, c. 151B, §4 and c. 272, §§92A, 98 and 98A. A true and genuine copy of the Charge is attached to this Complaint as Exhibit B.

16. Pursuant to c. 151B, §5, and the regulations promulgated thereto, 804 CMR 1.00 et seq., the MCAD, upon receipt of a Charge of Discrimination, is required to conduct a prompt investigation and determine whether there is sufficient evidence upon which a fact-finder could form a reasonable belief that it is more probable than not that the defendants committed an unlawful practice.

17. Pursuant to c. 151B, §5, and the regulations promulgated thereto, 804 CMR 1.00 et seq., in the event that a probable cause determination is made, the MCAD shall then certify the matter for public hearing after the completion of conciliation and discovery.

18. The MCAD has begun its investigation of the Charge. On or about November 30, 2007, and December 11, 2007, the MCAD notified the plaintiffs of the receipt of the Charge of Discrimination and the requirement that the plaintiffs submit a Position Statement, answering the allegations of discrimination asserted by the defendant Ms. Calderon.

19. Pursuant to 29 U.S.C. §1144, ERISA supercedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

20. Pursuant to 29 U.S.C. §1144, any state law that has the effect of specifying who must receive benefits under the terms of an employee benefit plan is preempted.

21. Pursuant to 29 U.S.C. §1144, ERISA's preemption of Mass. Gen. Laws, c. 151B, §4 and c. 272, §§92A, 98 and 98A is facially conclusive.

22. As such, any attempt by the state official defendants to investigate or adjudicate a claim concerning whether the Policy complies with Mass. Gen. Laws, c. 151B, §4 and c. 272, §§92A, 98 and 98A will interfere with the rights of plaintiffs to be free from state regulation of ERISA plans.

23. In light of ERISA's express preemption of such state laws and the MCAD's initiation of its investigation of the Charge, an actual controversy exists.

24. The plaintiffs seek a binding declaration that Mass, Gen. Laws c. 151B, §4, and c. 272, §§92A, 98 and 98A are preempted by ERISA, and that the MCAD therefore lacks jurisdiction to investigate, adjudicate and otherwise process Ms. Calderon's charge.

WHEREFORE, Plaintiffs request that the Court:

A. Declare that Mass. Gen. Laws, c. 151B, §4 and c. 272, §§92A, 98 and 98A are preempted by ERISA in connection with the Charge, and that the MCAD therefore does not have jurisdiction to entertain Ms. Calderon's claims;

B. Preliminarily and permanently enjoin the state official defendants from investigating, adjudicating or otherwise processing Ms. Calderon's Charge that the Policy, which is governed by ERISA, fails to comply with Massachusetts state law or regulations; and

C. Issue such other relief as is just and proper.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, AND UMASS MEMORIAL HEALTH CARE, INC.

By their attorneys,

/s/ Richard C. Van Nostrand

Richard C. Van Nostrand, Esq.
BBO #507900
Jessica H. Munyon, Esq.
BBO #658729
Mirick, O'Connell, DeMallie & Lougee, LLP
100 Front Street
Worcester, MA 01608-1477
Phone: (508) 791-8500
Fax: (508) 791-8502

Dated: January 23, 2008

**EXHIBIT A**

[LOGO]
COLONIAL
SUPPLEMENTAL INSURANCE

*for what happens next®*

Colonial Supplemental Insurance
P.O. Box 1365
Columbia, SC 29202-1365

385984737000

CAROLYN CALDERON
67 CHANNING ST
WORCESTER MA 01605-3709

We are providing the enclosed material at your request. It fully describes your benefits. We would like to take this opportunity to thank you for allowing Colonial Supplemental insurance to provide you with this insurance coverage.

When you choose Colonial Supplemental Insurance products, you choose more than just supplemental insurance. You choose quality benefits communications and education; fast, accurate and courteous customer service; and a broad selection of products to meet your individual needs, *for what happens next.*

At the bottom of this letter, you will find pertinent information about the coverage you purchased. Our toll-free service number and web site address provide you easy access to our Service Center. Please keep

this information available as a handy reference if you need to contact us.

You may reach the Colonial Service Center by U.S. mail, the Internet, telephone or fax. Just choose the option that is most convenient.

**U.S. Mail**
*For Claims*
Colonial Service Center
P. O. Box 100195
Columbia, South Carolina
29202-3195

*All Other Correspondence*
Colonial Supplemental Insurance
P. O. Box 1365
Columbia, South Carolina
29202-1365

**To Fax A Claim**
1-800-880-9325

**Internet**
***For name and address changes and downloading forms***
www.coloniallife.com

**Telephone** 1-800-325-4368
8 a.m. to 7 p.m. Eastern Time, Monday through Friday
Automated Service Center available 24 hours a day, 7 days a week (claim status, ordering forms, general information)

Colonial Supplemental Insurance products are underwritten by Colonial Life & Accident Insurance Company.

| | |
|---|---|
| [LOGO] COLONIAL SUPPLEMENTAL INSURANCE® | [LOGO] COLONIAL SUPPLEMENTAL INSURANCE® |
| CAROLYN CALDERON<br>POLICY/CERTIFICATE NUMBER<br>3 8598-473 70 CAROLYN | CAROLYN CALDERON<br>POLICY/CERTIFICATE NUMBER<br>3 8598-473 70 CAROLYN |
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| H 62<br>1204 | Underwitten by Colonial Life & Accident Insurance Company |
| Underwitten by Colonial Life & Accident Insurance Company | |

## SERVICE INFORMATION

### Contacting Colonial by Telephone

**Q: Whom do I call when I have a question about my coverage?**

**A:** Colonial has an Automated Service Center that is available seven days a week, 24 hours a day. When calling our toll-free number, **1-800-325-4368**, you will hear instructions on how to check the status of your claim, order forms, file a claim, and how to pay your premiums while on a leave of absence. If you need to speak to a customer service specialist for additional

details, you may do so during our normal business hours of 8 a.m. to 7 p.m. (Eastern Time), Monday through Friday. **1-800-325-4368**. Please have your Social Security or your policy number ready when you call.

Hearing Impaired customers can reach Colonial by calling **1-866-359-6719** on a TDD (Telecommunications Device for the Deaf).

**Contacting Colonial via the Internet**

**Q: Can I use the internet to contact Colonial?**

**A:** At **coloniallife.com**, you can download a claim form and other forms, file a wellness claim online, file a Loss of Life Notification, or e-mail us a question.

Colonial also offers ColonialConnect for Policyholders(sm), a secure web site designed for our customers who prefer to conduct business online. The web site offers an easy and convenient way for you to check the status of your claim, verify your contact information, and make name and address changes.

If you would like to learn more, logon to **coloniallife.com** for an online demo. To become a member, simply complete the membership request form and a representative will contact you by telephone to complete the registration process.

**Filing a Claim**

**Q: How do I file a claim?**

**A:** Submit a completed Colonial claim form to Colonial for processing by a claims specialist. The more complete your claim form, the quicker Colonial can process your request.

Colonial uses one standard form with most claims. Instructions for completing the form are noted on the form itself. To obtain a claim form, contact your employer or call the Colonial Service Center at **1-800-325-4368.**

If you have access to the Internet, forms may be downloaded at **coloniallife.com**, or request a form through our automated phone system. Complete the appropriate sections of the claim form and, where applicable, have your doctor and/or employer complete the form. Attach your medical bills and diagnosis to the form and mail or fax it to Colonial.

| **For Service and Information** | **For Service and Information** |
|---|---|
| **Service Center: 1-800-325-4368** | **Service Center: 1-800-325-4368** |
| **www.coloniallife.com** | **www.coloniallife.com** |
| **Fax Claim Forms to 1-800-880-9325** | **Fax Claim Forms to 1-800-880-9325** |
| **Mail Claim Forms to: P.O. Box 100195, Columbia, SC 29202** | **Mail Claim Forms to: P.O. Box 100195, Columbia, SC 29202** |

[LOGO]

**Unum's Commitment to Privacy**

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

**Collecting Information**

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

**Sharing Information**

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing

purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask you permission before sharing NPI that is not directly related to our transaction or experience with you.

**Safeguarding Information**

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

**Access to Information**

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

**Correction of Information**

If you believe NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

**Coverage Decisions**

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

**Contacting Us**

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C467, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following Insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.

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A-32442 (4-07)

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY**
**P.O. Box 1365, Columbia, South Carolina 29202**
**(800) 325-4368**

## DISABILITY INCOME COVERAGE

**THIS POLICY IS GUARANTEED RENEWABLE TO THE POLICY ANNIVERSARY DATE ON OR NEXT FOLLOWING YOUR 70TH BIRTHDAY. YOUR PREMIUM CAN BE CHANGED FOLLOWING THE APPROVAL OF THE COMMISSIONER OF INSURANCE ONLY IF WE CHANGE IT ON ALL POLICIES OF THIS KIND IN FORCE IN THE STATE WHERE THE POLICY WAS ISSUED.**

***POLICY ANNIVERSARY DATE* OCCURS ANNUALLY ON THE SAME DATE AND IN THE SAME MONTH AS THE DATE FOR WHICH WE FIRST RECEIVED PREMIUM.**

**Please Read This Policy Carefully**

This policy is a legal contract between you and us. Please read it carefully. We want you to be pleased with the coverage it provides. To understand your coverage, you must read this policy as a whole.

In this policy, the words *you* or *your* refer to the named insured identified on the Policy Schedule. The words *we, us* or *our* refer to Colonial Life & Accident Insurance Company.

**Coverage Provided by This Policy**

According to all the provisions of this policy, we insure the person shown in the Policy Schedule against losses resulting from total disability due to:

- covered accidents; or
- covered sicknesses.

**Your Right to Return This Policy Within 30 Days**

If, for any reason, you are not satisfied with this policy, you can return it to us at our administrative office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this policy as if it never existed. Any premium paid will be refunded to you.

**Pre-existing Condition**

Pre-existing condition means your having a sickness or physical condition for which you were treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of this policy.

If we do not pay a claim because the illness is a pre-existing condition, we will provide the insured with the following unless the information is confidential:

- a written denial letter; and
- the information we have documenting the treatment or observation of the pre-existing condition.

If the information is confidential, we will advise the insured only of the source of the information.

/s/ [Illegible]
Secretary

/s/ Jean E Durke
President & Chief
Financial Officer

Countersigned by _____
Licensed Resident Agent (if required by the state where you live)

---

**POLICY GUIDE**


Please Read This Policy Carefully ..... 1
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Your Right to Return This Policy Within 30 Days ..... 1
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Changes to This Policy ..... 4
Effective Date of This Policy ..... 4
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COLONIAL LIFE &
ACCIDENT INSURANCE COMPANY
POLICY SCHEDULE

NAMED INSURED CAROLYN CALDERON

BILLING CONTROL NUMBER E-745232-9

POLICY NUMBER 3 8598-473 70

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THIS POLICY PROVIDES THOSE BENEFITS
SHOWN IN THE POLICY SCHEDULE BELOW

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EFFECTIVE DATE OF COVERAGE 01-01-2007

TOTAL MONTHLY PREMIUM $62.88

| ACCIDENT | ON-JOB | OFF-JOB |
|---|---|---|
| TOTAL DISABILITY BENEFIT | | |
| BENEFIT PERIOD: | | |
| 6 MONTHS | | |
| ELIMINATION PERIOD: | | |
| 0 DAYS | NO | |
| MONTHLY BENEFIT AMOUNT | BENEFIT | $1700.00 |
| SICKNESS | | |
| TOTAL DISABILITY BENEFIT | | |
| BENEFIT PERIOD: | | |
| 6 MONTHS | | |
| ELIMINATION PERIOD: | | |
| 7 DAYS | NO | |
| MONTHLY BENEFIT AMOUNT | BENEFIT | $1700.00 |

## YOUR CONTRACT WITH US

**This Policy is a Contract** This policy is a legal contract between you and us. We provide the insurance coverage stated subject to the terms of this policy. We do this in return for your application and your first payment called a *premium*. The premium for this policy is shown in the Policy Schedule.

Whenever we use the word *policy*, we mean the entire contract. The entire contract consists of:

- this policy, including the Policy Schedule;
- the attached copy of the application; and
- any attached eiders or endorsements.

*Riders* and *endorsements* add provisions or change the terms of the policy.

**Changes to This Policy** Any changes made to this policy must be in writing and signed by one of our executive officers at our home office. No agent or anyone else can change

this policy or waive any of its provisions. You must sign any change that modifies, limits or excludes coverage in order for it to be binding.

**Effective Date of This Policy**

This policy begins at noon on the effective date shown in the Policy Schedule.

YOUR PREMIUM PAYMENTS

**When and Where to Pay Premiums**

The premiums for this policy must be paid to us at our home office in advance and when they are due.

The premium due dates are based on:

- the effective date of this policy shown in the Policy Schedule; and
- the premium frequency.

The *premium frequency* is how often you pay the premiums.

**Grace Period (If Premiums Are Not Paid When Due)**

After the first premium, if you do not pay a premium when it is due, you can pay it during the next 31 days. These 31 days are called the *grace period*. During this period this policy will

stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate.

Coverage ending at age 70 will not affect any disability that began while this policy was in force. The disability benefit will be limited to the payment of the applicable monthly benefit amount for the length of the applicable benefit period shown on the Policy Schedule.

**Our Right to Change Premiums**

We have the right to change the premium we charge. However, we cannot single anyone out for a premium change. If we make a change, it will be made on all policies of this kind in force in the state where the policy was issued. If we plan to make a change, we will send you a notice at least 45 days before we make it. We will not change premiums more than once in a 12-month period.

**Unpaid Premium**

When a claim is paid under this policy, any premium

then due end unpaid may be deducted from your claim payment.

**You Can Change the Way You Pay for This Policy**

If you would like to change the way you pay for this policy, you can notify us in writing at our home office.

**Reinstatement (How to Put This Policy Back In Force)**

If the premium is not paid by the end of the grace period, this policy will no longer be in force. However, you may be able to put the policy back in force. This is called *reinstatement.* You can ask us or one of our agents about reinstatement. If our home office accepts the premium and does not require a reinstatement application, this policy will be reinstated on the date the premium is paid.

If we do require a reinstatement application at the time we accept the premium, a conditional receipt will be given for the premium. If we approve the reinstatement application, this policy will be reinstated on the date we approve it. If we do not notify you that we have approved

or disapproved the reinstatement application, this policy will be reinstated on the 45th day after the date on the conditional receipt.

The reinstated policy will cover only disabilities that result from:

- covered accidents that occur after the reinstatement date; or
- covered sicknesses that begin more than 10 days after the reinstatement date.

We have the right to make changes in this policy before we reinstate it. Any changes will be made in or attached to the reinstated policy we send to you. In every other way, your rights and our rights will be the same.

## IMPORTANT WORDS IN THIS POLICY

**Activities of Daily Living**

*Activities of Daily Living* mean the following:

1. Dressing – the ability to put on and take off all garments and medically

necessary braces or artificial limbs usually worn

2. Transferring – the ability to move in or out of a chair or bed
3. Eating – the ability to get nourishment into the body once it has been prepared
4. Preparing meals
5. Toileting – the ability to get on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing

**Covered Accident**

A *covered accident* is an accident which:

- occurs after the effective date of this policy;
- is of a type listed on the Policy Schedule;
- occurs while this policy is in force; and
- is not excluded by name or specific description in this policy.

**Covered Sickness**

A *covered sickness* means an illness, infection, disease, pregnancy, complications of pregnancy or any other abnormal physical condition, not caused by an injury, which:

- occurs after the effective date of this policy;
- is of a type listed on the Policy Schedule;
- occurs while this policy is in force; and
- is not excluded by specific name or specific description in this policy.

**Doctor**

A *doctor* means a Person, other than you or a family member, who is licensed by the state to practice a healing art, and performs services for you which are allowed by his license. For the purposes of this definition, *family member* means your spouse, son, daughter, mother, father, sister or brother.

**Elimination Period**

*Elimination period* means the period of time during which no benefits are

payable, as shown in the Policy Schedule.

**Material and Substantial Duties**

*Material and substantial duties* of your job are defined as those job duties which:

- are normally required to perform your regular job; and
- cannot be reasonably modified or omitted.

Performing your job at a particular work site or in a particular building is not a material and substantial duty of your job, provided that your employer will allow you to perform your job at a different work site or in a different building.

**Off-Job Accident**

*Off-job accident* means an accident that occurs while you are not working at any job for pay or benefits.

**Off-Job Sickness**

*Off-job sickness* means a sickness that was not caused by or contributed to by your working at any job for pay or benefits.

**On-Job Accident**

*On-job accident* means an accident that occurs while

you are working at any job for pay or benefits.

**On-Job Sickness**

*On-job sickness* means a sickness that was caused by or contributed to by your working at any job for pay or benefits.

**Pre-Existing Condition**

*Pre-existing condition* means your having a sickness or physical condition for which you were treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of this policy.

If we do not pay a claim because the illness is a pre-existing condition, we will provide you with the following unless the information is confidential:

- a written denial letter; and
- the information we have documenting the treatment or observation of the pre-existing condition.

If the information is confidential, we will advise you

only of the source of the information.

**Recurrent Disability**

*Recurrent Disability* means your becoming disabled, ceasing to be disabled, then becoming disabled again for the same or related condition. The latter disability will be considered a recurrent disability.

**Totally Disabled**

*Totally disabled* means you are:

- unable to perform the material and substantial duties of your job;
- not, in fact, working at any job; and
- under the regular and appropriate care of a doctor.

**Under the Regular and Appropriate Care of a Doctor**

*Under the regular and appropriate care of a doctor* means you are being cared for on a regular basis by a doctor, and the care you are receiving is appropriate for the condition(s) which disable(s) you.

BENEFITS

**Total Disability Benefit** We will pay this benefit if you become totally disabled by a covered accident or by a covered sickness.

If you are disabled longer than the elimination period shown in the Policy Schedule we will pay the Total Disability benefit for as long as this coverage is in force and you remain totally disabled up to the benefit period and in the amount shown in the Policy Schedule, except as described in the Geographical Limitations provision. If benefits are payable for less than a full month, we will pay benefits in a daily amount. A *month* is 30 days. The *daily amount* is 1/30th of the monthly amount.

If you do not have a job when you become totally disabled, we will pay the total disability benefit only as long as you are kept at home and cannot perform two of five *Activities of Daily Living* and are *Under the Regular and Appropriate*

*Care of a Doctor. At home* means in your house or yard. However, you can follow your doctor's orders even if it means leaving home.

If you become disabled because of a pre-existing condition, we will not pay for any disability period if it begins during the first 12 months the policy is in force.

**Recurrent Disability**

A recurrent disability will be treated as:

- a continuation of the previous disability, not a new disability, if you have returned to work for less than six months.
- a new disability, if you have returned to work for six months or more, working at least the same number of hours you were working before the previous disability began.
- a new disability, if you did not have a job before the previous disability began and you have ceased to be disabled for six months or more.

- a continuation of the previous disability for any circumstances not specifically listed above.

A new disability is subject to a new elimination period, and a new benefit period applies. A disability that is considered a continuation of a previous disability is not subject to a new elimination period, and a new benefit period does not apply.

Any recurrent disability caused by a pre-existing condition will not be covered if it is treated as a continuation of the previous disability.

**Concurrent or Subsequent Disability**

Concurrent or Subsequent Disability: During any period in which you are disabled due to more than one condition, whether the conditions are related or unrelated, benefits will be paid as if you are disabled due to only one condition, in no event will your being disabled due to more than one condition extend the benefit period beyond the

benefit period shown in the Policy Schedule. Separate periods of disability resulting from unrelated conditions are considered a continuation of the previous disability, not a new disability, unless:

- they are separated by a minimum of 10 calendar days;
- during such time you returned to work performing the material and substantial duties of your job; and
- during such time you are no longer qualified to receive total disability benefits.

**Geographical Limitations**

If you become totally disabled as the result of a covered accident or a covered sickness while you are outside the covered geographical areas and you are totally disabled longer than the elimination period shown in the Policy Schedule, your maximum benefit period for total disability while outside the covered geographical areas will be

limited to 60 days. *Covered geographical areas* are less than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahama Islands, the Virgin Islands, Bermuda, or Jamaica.

After the 60 day period, benefits will not be paid until you return to the covered geographical areas.

If you are still totally disabled as defined in this policy when you return from outside the covered geographical areas, we will determine your remaining, applicable benefit period by subtracting the time period for which we have already paid you benefits from the benefit period shown in the Policy Schedule. We will pay the monthly benefit amount shown in the Policy Schedule for up to the remaining applicable benefit period.

**Waiver of Premium**

After you have been totally disabled as the result of a covered accident or a covered sickness for more than

90 consecutive days while this policy is in effect, or after the elimination period shown in the Policy Schedule, whichever is greater, we will waive the premium for the policy and any attached riders(s) for as long as you remain disabled, up to the benefit period shown in the Policy Schedule. You must pay all premiums to keep the policy and any attached rider(s) in force until you have been totally disabled for 90 consecutive days while this policy is in effect, or for the elimination period shown in the Policy Schedule, whichever is greater.

You must send us written notice as soon as you are no longer disabled. We will assume that you are no longer disabled if:

- you do not send us satisfactory proof of loss when we request it; or
- you notify us that you are no longer disabled.

You must pay all premiums to keep the policy and any

attached rider(s) in force beginning with the first premium due after you are no longer disabled.

The Waiver of Premium Benefit does not apply to any period that you are totally disabled due to an accident or sickness which is excluded by specific name or specific description in this policy.

There is no limit to the number of times you can receive the Waiver of Premium benefit.

WHAT IS NOT COVERED BY THIS POLICY

**We will not pay benefits for losses that are caused by or are the result of your:**

| | |
|---|---|
| **Alcoholism or Drug Addition** | Addiction to alcohol or drugs, except for drugs taken as prescribed by your doctor. |
| **Felonies or Illegal Occupations** | Committing or attempting to commit a felony, working at an illegal occupation and/or being incarcerated in a penal institution. |

| | |
|---|---|
| **Flying** | Operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger. |
| **Giving Birth** | Giving birth within the first nine months after the effective date of this policy as the result of a normal pregnancy, including Cesarean. Complications of pregnancy will be covered to the same extent as any other covered sickness. |
| **Hazardous Avocations** | Engaging in hang gliding, bungee jumping, parachuting, sailgliding, parasailing or parakiting or any similar activities. |
| **Pre-Existing Conditions** | Having a preexisting condition as described and limited by this policy. |
| **Psychiatric or Psychological Conditions** | Having a psychiatric or psychological condition including but not limited to affective conditions, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's Disease |

| | |
|---|---|
| | and other organic senile dementias are covered under this policy. |
| **Racing** | Riding in or driving any motor-driven vehicle in a race, stunt show or speed test. |
| **Semi-professional or Professional Sports** | Practicing for or participating in any semi-professional or professional competitive athletic contest for which you receive any type of compensation or remuneration. |
| **Suicide or Self-inflicted Injuries** | Committing or trying to commit suicide or your injuring yourself intentionally, whether you are sane or not. |
| **War or Armed Conflict** | Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. |

YOUR CLAIM FOR BENEFITS

| | |
|---|---|
| **How to File A Claim** | You must complete a claim form within 90 days after the covered loss begins or as soon as it is reasonably possible. Send the claim form along with proof of |

loss tows at our home office.

If you do not have a claim form, you must give us a written statement describing your loss within 90 days after the covered loss begins or as soon as it is reasonably possible. The statement should include your name and policy number as shown in the Policy Schedule. It must also include proof of loss and how the loss occurred. Send the statement to us at our home office. When we receive the statement describing the loss, we will send you claim forms within 15 days. If you do not receive claim forms, your written statement along with the proof of loss will be used to process your claim.

**Proof of Loss**

You must send us written proof of loss to our home office within 90 days after the covered loss begins. *Written proof of loss*, provided at your expense and in English or Spanish, must show:

- Your employer's statement verifying your last day of work, job title, duties, and the number of hours you were working per week; and
- Your attending doctor's statement verifying dates of disability, dates of treatment, diagnosis, and restrictions and limitations preventing you from performing your job.

We reserve the right to have you interviewed by an authorized company representative.

If you are self-employed when you become totally disabled, we will require that you provide a valid business license and/or filed federal tax returns as proof you are self-employed. We also reserve the right to require verification of any such information that you provide.

We can require written proof of loss at reasonable periods for a continuing disability covered by this policy. However, you must

give us proof no later than 90 days after the end of a period of loss for which we owe you benefits. If this policy provides benefits for up to two years for a period of loss, we will be responsible only for the six-month period for which you give us written proof of loss. This means that we will not pay benefits for a loss unless you continue to give us written proof of loss as required.

If you are not able to give us written proof of loss within 90 days, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

**Time of Payment of Claims**

After we receive written proof of loss and process your claim, we will immediately pay all benefits due. Benefits will be paid to you unless we receive written authorization to pay them elsewhere, such as to a

hospital or a doctor's office. This is called *assignment*.

If we still owe you benefits at your death, we will pay them to your estate.

If benefits are payable to your estate, we can pay benefits up to $1,000 to someone related to you by blood or marriage, whom we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

**Questions Concerning Your Claim**

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

**Physical Evaluation**

We will have the right and opportunity, at our own expense, to have you examined by a doctor, other health professional, vocational expert or rehabilitation expert of our choice. This right may be used as often as it is reasonably necessary while a claim is pending.

**Legal Action**

We cannot be sued for benefits under this policy:

- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

**How to Change Your Beneficiary**

You can ask us to change your beneficiary at any time. Unless you make an irrevocable designation of the beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be required to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy. Notify us, and we will send you the form to complete. The request must be witnessed by someone other than your present beneficiary or your proposed beneficiary and returned to us at our home office. The change must be approved by us. If approved,

it will go into effect the day you sign the request. The change will not have a bearing on any payment we make before we receive it.

## OTHER IMPORTANT PROVISIONS

**Time Limits on Certain Defenses**

We rely on the statements made by you in the application to issue this policy and pay benefits.

After this policy has been in force for two years, we cannot contest it or refuse to pay benefits because of any untrue statement in the application unless a fraudulent statement was made.

*Contest* means that we question the validity of coverage under this policy through a letter to you. This contest is effective on the date we mail the letter and refund the premium.

After this policy has been in force for 12 months from the effective date of this policy, we will pay benefits for any pre-existing condition not excluded by name

or specific description if the covered disability began 12 months after the effective date and the elimination period has been satisfied.

**Your Right to Continue Coverage**

We guarantee that you can keep this policy in force to age 70 as long as the premiums are paid when due. They can be paid:

- anytime before they are due; or
- within the grace period.

**Error in Age**

If you stated your age incorrectly in the application and if, based on your correct age, we would not have issued this policy, then our only responsibility will be to refund the premiums paid for the period not covered, if any.

If you stated your age incorrectly in the application and this policy could have been issued at your correct age; we will pay the amount of benefits that the premium paid would have purchased at your true age at the time of application.

| | |
|---|---|
| **Transfer of Rights** | You can assign any rights you have under this policy. However, no assignment is binding on us until we receive a copy of it. We are not responsible for the validity of any assignment. |
| **State Laws** | Any provision of this policy that, on the effective date, does not agree with state laws where you live will be amended to conform to the minimum requirements of those laws. |
| **Extension of Benefits** | Termination of this policy will be without prejudice to any continuous loss which began while this policy was in force. However, extension of benefits will be limited to the duration of the policy benefit period or payment of the maximum benefits. |

**COLONIAL LIFE &**
**ACCIDENT INSURANCE COMPANY**
**P.O. Box 1365, Columbia, South Carolina 29202**
**(800) 328.4368**
**DISABILITY INCOME COVERAGE**
**OUTLINE OF COVERAGE**
**(Applicable to Policy Form DIS 1000-MA)**

**Disability Income Coverage.** Your policy is designed to provide coverage for disabilities that result from covered accidents or covered sicknesses subject to any limitations or exclusions. It does not provide coverage for basic hospital, basic medical-surgical or major medical expenses.

**Coverage Provided by the Policy.** We will pay the total disability benefit shown, in the Policy Schedule if you become totally disabled and are totally disabled longer than the elimination period as the result of a covered accident or covered sickness while the policy is in force.

**Benefits for Total Disability.** Benefits are payable if you become totally disabled by a covered accident or covered sickness, based on the plan you choose.

On-Job Off-Job Amount ___ Benefit Period ___
Amount ___

If benefits are payable for less than a full month, we will pay the appropriate benefits on a daily basis. A month is 30 days. The daily amount is 1/30th of the monthly amount.

If you do not have a job when you become totally disabled, we will pay the total disability benefit only as long as you are kept at home and cannot perform two of five Activities of Daily Living and you are under the regular and appropriate care of a doctor.

Recurrent Disability: A recurrent disability will be treated as:

- a continuation of the previous disability, not a new disability, if you have returned to work for less than six months.
- a new disability, if you have returned to work for six months or more, working at least the same number of hours you were working before the previous disability began.
- a new disability, if you did not have a job before the previous disability began and you have ceased to be disabled for six months or more.
- a continuation of the previous disability for any circumstances not specifically listed above.

A new disability is subject to a new elimination period, and a new benefit period applies. A disability that is considered a continuation of a previous disability is not subject to a new elimination period, and a new benefit period does not apply.

Any recurrent disability caused by a pre-existing condition will not be covered if it is treated as a continuation of the previous disability.

If you become disabled because of a pre-existing condition, we will not pay for any disability period if

it begins during the first 12 months the policy is in force.

Concurrent or Subsequent Disability: During any period in which you are disabled due to more than one condition, whether the conditions are related or unrelated, benefits will be paid as if you are disabled due to only one condition. In no event will your being disabled due to more than one condition extend the benefit period beyond the benefit period shown in the Policy Schedule. Separate periods of disability resulting from unrelated conditions are considered a continuation of the previous disability, not a new disability, unless:

- they are separated by a minimum of 10 calendar days;
- during such time you returned to work performing the material and substantial duties of your job; and
- during such time you are no longer qualified to receive total disability benefits.

This coverage will end on the policy anniversary date on or next following your 70th birthday. Coverage ending at age 70 will not affect any disability that began while the policy was in force. The disability benefit will be limited to the payment of the applicable monthly benefit amount for the length of the applicable benefit period shown on the Policy Schedule.

We will provide the maximum amount and benefit period shown in the Policy Schedule.

Your policy is guaranteed renewable to the policy anniversary date on or next following your 70th birthday. Your premium can be changed following the approval of the Commissioner of Insurance only if we change it on all policies of this kind in force in the state where the policy was issued.

We have the right to change the premium we charge. However, we cannot single anyone out for a premium change. If we make a change, it will be made on all policies of this kind in force in the state where the policy was issued. If we plan to make a change, we will send you a notice at least 45 days before we make it. We will not change premiums more than once in a 12-month period.

We will not pay benefits for losses that are caused by or are the result of your having a pre-existing condition. Pre-existing condition means your having a sickness or physical condition for which you were treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of the policy.

We will not pay benefits for losses that are, caused by or are the result of your having a psychiatric or psychological condition including, but not limited to, affective conditions, neuroses, anxiety, stress and adjustment reactions.

We will not pay benefits for losses that are caused by or are the result of your giving birth within the first nine months after the effective date of the policy as the result of a normal pregnancy, including Cesarean.

Complications of pregnancy will be covered to the same extent as any other covered sickness.

If, for any reason, you are not satisfied with the policy, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider the policy as if it never existed. Any premium paid will be refunded to you.

**Read your policy carefully.** This outline provides a very brief description of the important features of your policy. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and us. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

**Time Limits**

After the policy has been in force for 12 months from the effective date of the policy, we will pay benefits for any pre-existing condition not excluded by name or specific description if the covered disability began 12 months after the effective date and the elimination period has been satisfied.

**Geographical Limitations**

if you become totally disabled as the result of a covered accident or a covered sickness while you are outside the covered geographical areas and you are totally disabled longer than the elimination period

shown in the Policy Schedule, your maximum benefit period for total disability while outside the covered geographical areas will be limited to 60 days. Covered geographical areas are less than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahama Islands, the Virgin Islands, Bermuda or Jamaica.

After the 60-day period, benefits will not be paid until you return to the covered geographical areas.

If you are still totally disabled as defined in the policy when you return from outside the covered geographical areas, we will determine your remaining applicable benefit period by subtracting the time period for which we have already paid you benefits from the benefit period shown in the Policy Schedule. We will pay the monthly benefit amount shown in the Policy Schedule for up to the remaining applicable benefit period.

**Waiver of Premium Benefit**

After you have been totally disabled as the result of a covered accident or a covered sickness for more than 90 consecutive days while the policy is in effect, or after the elimination period shown in the Policy Schedule, whichever is greater, we will waive the premium for the policy and any attached rider(s) for as long as you remain disabled, up to the benefit period shown in the Policy. Schedule. You must pay all premiums to keep the policy and any attached rider(s) in force until you have been totally disabled

for 90 consecutive days while the policy is in effect, or for the elimination period shown in the Policy Schedule, whichever is greater.

You must send us written notice as soon as you are no longer disabled. We will assume you are no longer disabled if:

- You do not send us satisfactory proof of loss when we request it; or
- You notify us that you are no longer disabled.

You must pay all premiums to keep the policy and any attached rider(s) in force beginning with the first premium due after you are no longer disabled.

The Waiver of Premium Benefit does not apply to any period that you are totally disabled due to an accident or condition which is excluded by specific name or specific description in the policy.

There is no limit to the number of times you can receive the Waiver of Premium benefit.

**Important Words in the Policy**

*Activities of Daily Living* mean the following:

1. Dressing – the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn
2. Transferring – the ability to move in or out of a chair or bed

3. Eating – the ability to get nourishment into the body once it has been prepared
4. Preparing meals
5. Toileting – the ability to get on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing

A *covered accident* is an accident which:

- occurs after the effective date of the policy;
- is of a type listed on the Policy Schedule;
- occurs while the policy is in force; and
- is not excluded by name or specific description in the policy.

A *covered sickness* means an illness, infection, disease, pregnancy, complications of pregnancy or any other abnormal physical condition, not caused by an injury, which:

- occurs after the effective date of the policy;
- is of a type listed on the Policy Schedule;
- occurs while the policy Is In force; and
- is not excluded by specific name or specific description in the policy.

A *doctor* means a person, other than you or a family member, who is licensed by the state to practice a healing art, and performs services for you which are allowed by his license. For the purposes of this

definition, *family member* means your spouse, son, daughter, mother, father, sister or brother,

*Elimination period* means the period of time during which no benefits are payable, as shown in the Policy Schedule.

*Material and substantial duties of your job* are defined as those job duties which:

- are normally required to perform your regular job; and
- cannot be reasonably modified or omitted.

Performing your job at a particular work site or in a particular building is not a material and substantial duty of your job, provided that your employer will allow you to perform your job at a different work site or in a different building.

*Off-job accident* means an accident that occurs while you are not working at any job for pay or benefits.

*Off-job sickness* means a sickness that was not caused by or contributed to by your working at any job for pay or benefits.

*On-job accident* means an accident that occurs while you are working at any job for pay or benefits.

*On-job sickness* means a sickness that was caused by or contributed to by your working at any job for pay or benefits.

*Pre-existing condition* means your having a sickness or physical condition for which you were treated, had

medical testing, received medical advice or had taken medication within 12 months before the effective date of the policy.

*Recurrent disability* means your becoming disabled, ceasing to be disabled, then becoming disabled again for the same or related condition. The latter disability will be considered a recurrent disability.

*Totally disabled* means you are:

- unable to perform the material and substantial duties of your job;
- not in fact, working at any job; and
- under the regular and appropriate care of a doctor.

*Under the regular and appropriate care of a doctor* means you are being cared for on a regular basis by a doctor and the care you are receiving is appropriate for the condition(s) which disable(s) you.

**What is Not Covered by the Policy**

We will not pay benefits for losses that are caused by or are the result of your:

- addiction to alcohol or drugs, except for drugs taken as prescribed by your doctor;
- operating, learning to operate, or serving as a crew member of or jumping or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger.

- giving birth within the first nine months after the effective date of the policy as the result of a normal pregnancy, including Cesarean. Complications of pregnancy will be covered to the same extent as any other covered sickness;
- engaging in hang gliding, bungee jumping, parachuting, sailgliding, parasailing or parakiting or any similar activities;
- committing or attempting to commit a felony, working at an illegal occupation and/or being incarcerated in a penal institution;
- having a pre-existing condition as described and limited by the policy;
- having a psychiatric or psychological condition including, but not limited to, affective conditions, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's Disease and other organic senile dementias are covered under the policy;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- practicing for or participating in any semi-professional or professional competitive athletic contest for which you receive any type of compensation or remuneration;
- committing or trying to commit suicide or your injuring yourself intentionally, whether you are sane or not; or
- being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority.

**Your Right to Return This Policy Within 30 Days.** If, for any reason, you are not satisfied with this policy, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this policy as if it never existed. Any premium paid will be refunded.

**Complaints.** If you have a complaint, call us at (800) 325-4368. If you are not satisfied, you can write to the Massachusetts Division of Insurance, One South Station, Boston, MA, 02210; or call them at (617) 521-7794.

**EXHIBIT B**

(Received: Dec. 4, 2007)

**The Commonwealth of Massachusetts**
**Commission Against Discrimination**
**436 Dwight Street, Rm. 220, Springfield, MA 01103**
**Phone: (413) 739-2145 Fax: (413) 784-1056**

11/30/2007

Colonial Life & Accident Insurance Company
P.O. Box 1365
Columbia, SC 29202

RE: Carolyn Calderon vs. Colonial Life & Accident Insurance Company, UMass Memorial Health Care
MCAD Docket Number: 07SEM03201
EEOC/HUD Number: 16C-2008-00423

Dear Respondent Party:

The Massachusetts Commission Against Discrimination (MCAD) has received the above complaint of discrimination which alleges that you have committed an act of discrimination against the complainant. A copy of that complaint is enclosed.

State law requires the Commission to impartially review the allegations in that complaint. The Commission has assigned one of its staff, Maryann Brunton, to investigate the complaint. This MCAD investigator will keep the parties informed of the course of the investigation.

State law requires that you submit a formal written answer to the complaint, called a Position Statement.

This Position Statement must be submitted within twenty-one (21) days of receipt of this notification. The Position Statement must be signed under the pains and penalties of perjury. A copy must also be forwarded to the Complainant at the address listed on the enclosed complaint. Failure to file a Position Statement or other response within the prescribed time may result in sanctions being imposed in accordance with 804 CMR 1.16.

It is our policy to determine whether the parties are willing to consider a rapid, informal and voluntary resolution of this dispute. The commission encourages such resolutions as an alternative to the often lengthy and expensive litigation process. To discuss the possibility of settlement, please contact the Investigator named below.

Please be advised that Position Statements are to be addressed to Carol Murchison, Administrative Assistant. If you have any questions concerning Position Statements please call (413) 739-2145 x. 46129.

If you have any questions pertaining to the Investigation, please contact Maryann Brunton at (413) 739-2145 x. 46102.

Sincerely,

Maryann Brunton
Investigator

Cc:

**EQUAL EMPLOYMENT OPPORTUNITY COMMISSION**

Colonial Life & Accident Insurance Company
P.O. Box 1365
Columbia, SC 29202

UMass Memorial Health Care
365 Plantation Street
Worcester, MA 01605

| | |
|---|---|
| Person Filing Charge: | Carolyn Calderon |
| This Person (Check One): | (✓) Claims to be aggrieved |
| | ( ) Is filing on behalf of |
| Date of Alleged Violation: | 06/21/07 |
| Place of Alleged Violation: | Worcester, |
| EEOC Charge Number: | 16C-2008-00423 |
| MCAD Docket Number: | 07SEM03201 |

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NOTICE OF CHARGE OF DISCRIMINATION WHERE AN FEP AGENCY WILL INITIALLY PROCESS (See Attached Information Sheet For Additional Information)

You are hereby notified that a charge of employment discrimination under

[ ] Title VII of the Civil Rights Act of 1964

[ ] The Age Discrimination in Employment Act of 1967 (ADEA)

[✓] The Americans Disabilities Act (ADA)

Has been received by

[ ] The EEOC and sent for initial processing to *MCAD* (FEP Agency)

[✓] *The Mass. Commission Against Discrimination* (FEP Agency and sent to the EEOC for dual filing purposes.

While the EEOC has jurisdiction (upon the expiration of any deferral requirements if this is a Title VII or ADA Charge) to investigate this charge, EEOC may refrain from beginning an investigation and await the issuance of the Agency's final findings and orders. These final findings and orders will be given weight by EEOC in making its own determination as to whether or not reasonable cause exists to believe that the allegations made in the charge are true.

You are therefore encouraged to cooperate fully with the Agency. All facts and evidence provided by you to the Agency in the course of its proceedings will be considered by the Commission when it reviews the Agency's final findings and orders. In many instances the commission will take no further action, thereby avoiding the necessity of an investigation by both the Agency and the Commission. This likelihood is increased by your active cooperation with the Agency.

[X] As a party to the charge, you may request that EEOC review the final decision and order of the above named Agency. For such a request to be honored, you must notify the Commission in writing within 15 days of your receipt of the Agency's issuing a final finding and order. If the agency terminates its proceedings without issuing a final finding and order, you will be contacted further by the commission. Regardless of whether the Agency or the Commission processes

the charge, the Recordkeeping and Non-Retaliation provisions of Title VII and the ADEA as explained on the second page of this form apply.

*For further correspondence on this matter, please use the charge number(s) shown.*

[ ] An Equal Pay Act Investigation (29 U.S.C 206(d) will be conducted by the Commission concurrently with the Agency's investigation of the charge.

[X] Enclosure: Copy of the Charge

| | | |
|---|---|---|
| ( ) Race | (✓) Disability | ( ) Religion |
| ( ) Age | ( ) Sex | ( ) Other |
| ( ) Color | ( ) Retaliation | ( ) National Origin |

Circumstances of alleged violation:

SEE ENCLOSED COPY OF THE CHARGE OF DISCRIMINATION (or EEOC FORM 5)

| Date | Type Name/Title of Authorized EEOC Official | Signature |
|---|---|---|
| 11/30/2007 | Robert L. Sanders, Director | |

## CHARGE OF DISCRIMINATION

This form is offered by the Privacy Act of 1974; see Privacy Act Statement on reverse before completing this form.

[Illegible]

☐ FCPA 07-23-03201
☐ EEOC 16C-2008-00423

Massachusetts Commission Against Discrimination
(*State or local Agency, if any*) and EEOC.

NAME (*Indicate Mr., Ms., or Mrs.*)
Ms. Carolyn Calderon

HOME TELEPHONE NO. (*Include Area Code*)
(508) 688-9153

STREET ADDRESS CITY, STATE AND ZIP CODE
[Home Address Omitted]

COUNTY

NAMED IS THE EMPLOYER, LABOR ORGANIZATION, EMPLOYMENT AGENCY, APPRENTICESHIP COMMITTEE, STATE OR LOCAL GOVERNMENT AGENCY WHO DISCRIMINATED AGAINST ME (*If more than one list below*).

NAME Colonial Life & Accident Insurance Co.

NO. OF EMPLOYEES/MEMBERS Over 50

TELEPHONE NUMBER (*Include Area Code*)

STREET ADDRESS CITY, STATE AND ZIP CODE
P.O. Box 1365 Columbia SC 29202

NAME U Mass Memorial Health Care

TELEPHONE NUMBER (*Include Area Code*) _____

STREET ADDRESS CITY, STATE AND ZIP CODE
365 Plantation Street Worcester MA 01605

CAUSE OF DISCRIMINATION BASED ON (*Check appropriate box(es)*)

☐ RACE ☐ COLOR ☐ SEX ☐ RELIGION
☐ NATIONAL ORIGIN ☐ AGE ☐ RETALIATION
☒ OTHER (*Specify*) DISABILITY

DATE MOST RECENT OR CONTINUING DISCRIMINATION TOOK PLACE (*Month, day, year*)
6/21/2007

THE PARTICULARS ARE (*If additional space is needed, attached extra sheet(s)*):

Please see November 13, 2007 letter/complaint to MCAD from Susan Fendell, Esq. on behalf of Carolyn Calderon.

☒ I also want this charge filed with the EEOC. I will advise the agencies if I change my address or telephone number and I will cooperate fully with them in the processing of my charge in accordance with their procedures.

NOTARY – (When necessary to meet State and Local Requirements)

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I swear or affirm that I have read the above charge and that it is true to the best of my knowledge, information and belief.

I declare under penalty of perjury that the foregoing is true and correct.

Date 11/26/07

Charging Party (*Signature*) /s/ Carolyn E. Calderon

SIGNATURE OF COMPLAINANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS DATE: (Month, day and year)

---

[LOGO]
FRANK LASKI
EXECUTIVE
DIRECTOR

**The Commonwealth of Massachusetts**
**MENTAL HEALTH LEGAL ADVISORS COMMITTEE**

**399 WASHINGTON ST., 4TH FLOOR**
**BOSTON, MA 02108**
**TEL: (617) 338-2345**
**FAX: (617) 338-2347**

November 13, 2007

(Received Nov. 2007)

Massachusetts Commission Against Discrimination
One Ashburton Place
Boston, MA 02108

RE: Complaint of Carolyn Calderon vs. U Mass Memorial Health Care and Colonial Accident & Life Insurance Co.

Dear Sir/Ms.

On behalf of Carolyn Calderon, Mental Health Legal Advisors Committee is filing a complaint against U Mass Memorial Health Care ("employer") and Colonial Accident & Life Insurance Co., the employer's short-term disability insurer.

Ms. Calderon is employed by U Mass Memorial Health Care, 365 Plantation Street, Worcester, MA 01605, and insured by Colonial Accident & Life Insurance Co., P.O. Box 1365, Columbia, SC 29202. Ms. Calderon was totally unable to work from May 8, 2007 to August 1, 2007 because she was disabled by major depression, anxiety and panic disorder. She did not return to work full-time until September 1, 2007.

Ms. Calderon is a qualified handicapped individual for the purposes of this complaint.

On May 15, 2007, Ms. Calderon applied for short-term disability benefits through the policy offered by her employer. She received a letter dated May 30, 2007 stating that she was being denied benefits because the policy did not pay benefits for psychiatric or psychological conditions and she was disabled from such a condition. (See enclosed denial letter.) Ms. Calderon appealed this determination and submitted a letter from her doctor, Katharine Barnard, dated June 6, 2007. Ms. Calderon was again denied benefits by letter dated June 21, 2007 (enclosed).

The employer violated Chapter 151B, §4 and the Americans with Disabilities Act of 1990, § 2 et seq.[1] by providing benefits that discriminate against persons with mental disabilities. Chapter 151B §4, which prohibits discrimination based upon a person's disability, is applicable to an employer ("16. For any employer, personally or through an agent, to dismiss from employment or refuse to hire, rehire or advance in employment or otherwise discriminate against, because of his handicap, any person alleging to be a qualified handicapped person).

Likewise, the insurer violated Part II of the ADA[2], Chapter 151B §4, and M.G.L. c.272, §§ 92A, 98 and

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[1] 42 U.S.C.A. § 12101 et seq.

[2] "It shall be discriminatory to provide an individual . . . on the basis of a disability with a good [or] service . . . that is

(Continued on following page)

98A. The insurer provides public accommodation of disability insurance and by excluding only persons with mental disabilities, it illegally discriminates against persons with mental disabilities. Furthermore, Chapter 151B §4 prohibits the aiding and abetting of activities prohibited by this chapter. ("5. For any person, whether an employer or an employee or not, to aid, abet, incite, compel or coerce the doing of any of the acts forbidden under this chapter or to attempt to do so.") Colonial clearly intended to engage in the limitation of benefits to a particular class of individuals based upon their disability. (Policy enclosed.)

This type of discrimination is prohibited; employers and disability insurance companies may not favor one set of persons with physical disabilities over persons with mental disabilities. *Samartin v. Metropolitan Life Ins. Co.*, 2005 WL 2993469 (MCAD 2005) (Docket No. 97-SPA-0383)[3], *Iwata v. Intel Corp.*, 349 F.Supp.2d 135 (D. Mass. 2004), and *Fletcher v. Tufts*

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different from that provided to other individuals unless such action is necessary to provide the individual with a good [or] service . . . that is as effective as that provided to others." ADA, 42 U.S.C. §12182(b)(1)(A)(iii).

[3] "The Long-Term Disability insurance benefit provided to Complainant was part of a benefit package constituting the terms, conditions and privileges of his employment. Any attempt by Respondent to terminate or limit such benefits on account of his specific handicap constitutes discrimination in the terms, conditions or privileges of his employment." *Samartin* at 5.

*University*, 367 F.Supp.2d 99 (D. Mass. 2005), all support Ms. Calderon's complaint.

Sincerely

/s/ Susan Fendell
Susan Fendell
Senior Attorney

cc: Carolyn Calderon
Enclosures

---

Certificate of Service

I hereby certify that true and correct copies of the letter of complaint and enclosures were served upon Colonial Accidental Life Insurance Co., 1200 Colonial Life Boulevard, Columbia, SC 29202, ATT:John Garrison, and Muriel Fraker, U Mass Memorial Medical Center, Office of General Counsel, 370 Main Street, 3rd Floor, Worcester, MA 01608, by first class U.S. mail, postage prepaid, on this 13th day of November, 2007.

/s/ Susan Fendell
Susan Fendell

[LOGO]
COLONIAL
SUPPLEMENTAL INSURANCE

*for what happens next*
PO Box 100195
Columbia, SC 29202

May 30, 2007

Carolyn Calderon
67 Channing St
Worcester, MA 01605

We are writing in reference to:
Claimant: Carolyn Calderon
Claim Number: 03859847370010 984946992
Date of Loss: 05/08/2007

After completing our evaluation of your recent claim, we regret there are no benefits payable at the present time for the following reason(s):

* Your disability policy pays benefits for health conditions, but it does not pay benefits for psychiatric or psychological conditions. The information we received indicates your claim is for psychiatric or psychological conditions.

* The medical information received from your doctor confirms you are unable to work due to grief reaction and panic disorder. Since these conditions are excluded by your policy, we will be unable to provide benefits for this claim.

At Colonial Life & Accident Insurance Company, we review every claim in a thorough and timely manner because we want our policyholders to receive all the

benefits their coverage can provide. You are a valued customer, and we want to ensure you understand your coverage and its benefits.

We hope this letter explains our evaluation of your claim. However, if you believe our understanding of the facts is incorrect, or if you have additional information concerning this claim, please submit that information in writing to our office.

Sincerely,

Claims Department
Colonial Life & Accident Insurance Company

For additional assistance, contact our Customer Service Center at 1-800-325-4368. Service Specialists are available Monday-Friday, 8 a.m.-7 p.m., ET.

For your convenience, we also offer an Automated Services Center at the number above to order forms, hear instructions about how to complete a claim form, receive a current claim status or to change your mailing address. These features are available 24 hours, every day of the year, and do not require that you speak to a service representative.

Reference:
E74523290000 Umass Memorial Health Care FBP R1 JXS

[LOGO]
COLONIAL
SUPPLEMENTAL INSURANCE

*for what happens next*
PO Box 100195
Columbia, SC 29202

June 21, 2007

Carolyn Calderon
67 Channing St
Worcester, MA 01605

We are writing in reference to:
Claimant: Carolyn Calderon
Claim Number: 03859847370010 984946992
Date of Loss: 05/08/2007

You are a valued customer, and we want to ensure you understand your policy and its benefits. To provide you with more details regarding your recent claim evaluation, here is some additional information:

* We have received the 06/06/2007 letter from Dr. Barnard and the 06/11/2007 letter from Carol Virostek.

Based on these letters it appears your disabling diagnoses are major depressive disorder, panic disorder and grief reaction. Dr. Barnard states you are unable to work due to physical symptoms associated with your conditions. However, your policy does not provide benefits for disability that is caused by or occurs as a result of psychiatric or psychological condition. Because your symptoms are caused by a

psychiatric condition, we are unable to consider benefits for this claim.

If you have been diagnosed with a covered physical condition and this condition has caused you to be unable to work, we will need a statement from your doctor that provides the diagnosis of this physical condition, the treatment you are receiving for this condition and the restrictions/limitations due to this condition that prevent you from working.

We hope this clarifies the evaluation of your claim. However, if you believe our understanding of the facts is incorrect or if you have additional information concerning this claim, please let us know as soon as possible. Just call our Customer Service Center, and we will be happy to assist you.

Sincerely,

Claims Department
Colonial Life & Accident Insurance Company

THE COMMONWEALTH OF MASSACHUSETTS
COMMISSION AGAINST DISCRIMINATION
436 DWIGHT STREET, SUITE 220
SPRINGFIELD, MA 01103

Tel: (413) 739-2145 Fax: (413) 784-1056

[LOGO]
Deval L. Patrick
Governor
Timothy P. Murray
Lieutenant Governor

Leslie A. Kirwan
Secretary

[LOGO]
Walter J. Sullivan,
Chairman
Dorca I. Gómez
Commissioner

Martin S. Ebel
Commissioner

## STANDING ORDER OF THE SPRINGFIELD MCAD OFFICE REGARDING EXTENSIONS DURING THE INVESTIGATIVE PROCESS

Please be advised that the Springfield office of the Massachusetts Commission Against Discrimination is implementing this policy regarding the *granting of extensions* during the investigative process.

**The policy is as follows:**

***You are allowed to request a TOTAL of twenty-five days for extensions during the investigative process in writing.***

**This means that the total number of days you may receive is NOT TO EXCEED twenty-five days during the ENTIRE INVESTIGATION.** For instance, if you request and receive a twenty-one day extension to submit your position statement, you then have a balance of four days to submit all

additional information requested by the commission. Our advice is to use your extensions sparingly and plan ahead for emergencies.

If you are an attorney and you do not believe that you can abide by this policy, then you may want to reconsider whether you should become involved in representing parties during the investigative process at the MCAD.

**If you violate the extension rule, be prepared to incur sanctions payable to the Commonwealth of Massachusetts, which if ordered, will be strictly enforced.**

We are working vigorously to improve the investigative process here at MCAD. Our goal is to improve the quality of investigations while reducing the time frame needed to complete them. This policy is designed to assist us in reaching these goals and will be applied equally to both parties, the complainant and respondent.

We appreciate your assistance regarding the enforcement of this policy.

/s/ Martin S. Ebel
Martin S. Ebel,
Commissioner, Western Mass. Office

**EXHIBIT C**

**UMass Memorial**

**Disability Benefits**

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## WHERE TO CALL FOR INFORMATION

| **For Information About . . .** | **Call . . .** |
|---|---|
| Your disability coverage | **1-508-334-1999**<br>■ To enroll<br>■ If you have questions about your coverage options<br>■ To request a claim form<br>■ To request an Evidence of Insurability (EOI) form |

| | |
|---|---|
| Short-Term Disability (STD) benefits | **Colonial Life & Accident Insurance Company**<br>**1-800-325-4368**<br>**or**<br>**Medical Life Insurance Company**<br>**1-800-692-1400**<br>■ To file a claim for benefits<br>■ For information about the status of a claim |
| Long-Term Disability (LTD) benefits | **UNUM Life Insurance Company of America**<br>**1-800-858-6843**<br>■ To file a claim for benefits<br>■ For information about the status of a claim |

## YOUR DISABILITY BENEFITS

When you are healthy and working hard, it's hard to imagine how an extended illness could affect your personal and financial situation. The fact is, though, that when you are injured and unable to work, you do not receive your regular paycheck. Yet, your expenses continue. To assist you through these times, UMass Memorial offers financial security through the short-term and long-term disability programs.

- Short-Term Disability (STD) pays a percentage of your weekly pay for up to six months (180 days)

if you are unable to work due to an illness or injury.

- Long-Term Disability (LTD) pays a percentage of your base monthly salary if your disability keeps you out of work for six months or longer.

## DISABILITY BENEFITS

| | Short-Term Disability (STD) | Long-Term Disability (LTD) |
|---|---|---|
| Who is Eligible | Anyone who occupies a position budgeted for at least 20 hours per week | |
| Cost of Coverage | Coverage is optional. You pay the full cost, if you elect it | UMass Memorial pays the full cost of coverage* |
| Benefit Amount | Can be customized based on your needs | After six months, you receive LTD benefits equal to 55%* of your base monthly salary |

*If you elect coverage under the Supplemental LTD plan, you pay a portion of the cost and receive a benefit equal to 66-⅔% of your base monthly salary.

## SHORT-TERM DISABILITY

Short-Term Disability (STD) coverage replaces a portion of your weekly income if you cannot work due to illness, injury or pregnancy. This coverage is voluntary. If you are interested in this type of financial security, you have a choice between two

different STD programs. Under both programs your premium payments are paid through convenient payroll deduction.

### Eligibility

You are eligible to participate in the short-term disability if you occupy a position budgeted for at least 20 hours per week.

### Enrollment

As a new employee, you must enroll within 30 days of your hire date. If you don't elect coverage when you are first eligible, you may enroll in the individual STD plan at any time and the group plan during any future open enrollment period. Once you enroll, your coverage becomes effective when the insurance carrier approves your application.

### Paying for Coverage

You pay the full cost of this coverage. Your cost varies based on your age, the program option you select, and the level of income replacement you elect. Also, you may choose to pay your premium on either a pre-tax or post-tax basis for the individual plan. Under the group plan, you must pay your premium on a post-tax basis.

## STD PREMIUM PAYMENTS

| Pre-Tax | Post-Tax |
|---|---|
| You enjoy tax savings on the amount of your premium. Any benefits paid to you as the result of a disability are considered taxable income. | Any benefit paid to you as the result of a disability is paid to you on a tax-free basis. |
| You can only change your coverage during the open enrollment period each year. | You may terminate your coverage at any time. |

### Amount of Benefits

**Weekly Income Means . . .**

Your gross weekly pay (before taxes and pre-tax deductions are withheld) at the time your disability began. It excludes overtime, bonus and shift differential.

If you are unable to work due to an illness or injury, the plan replaces a portion of your weekly pay based on the option you select. For purposes of this plan, your weekly income means your base pay. It does not include bonuses, overtime pay or other extra compensation.

**Your Coverage Options**

You have a choice between two STD Programs: one offered through Colonial Life & Accident Insurance company and another through Medical Life Insurance Company. Both programs replace a portion of your pre-disability income. Other features vary – such as when benefit payments begin and the length of time that payments continue.

Because of their differences, the programs also vary in cost. So that you can make a choice that's right for you, we encourage you to learn how each program works. Here is a brief description so you can understand better how they compare to one another.

**SHORT-TERM DISABILITY COVERAGE**

| | **Colonial Life & Accident Individual Plan** | **Medical Life Group Plan** |
|---|---|---|
| ***When benefits begin*** | Based on your selection. | After 15 days. |
| ***How long benefits continue*** | When you enroll, you select either a 3-month or 6-month coverage period. | For up to 26 weeks. |

| | | |
|---|---|---|
| ***Amount of weekly income provided*** | You choose the weekly amount. You may replace up to 66-⅔% of your pre-disability pay, up to $3,000 per month. | You choose the weekly amount. You may replace up to 70% of your pre-disability pay, up to $750 per week. |
| ***Your cost*** | You pay the full cost. It's based on your age and the amount of coverage you elect. | |
| ***Other features to consider*** | You can elect to continue this coverage if you terminate employment at UMass Memorial. | This coverage includes an Accidental Death and Dismemberment benefit (at no additional charge). |
| ***When benefits are not provided*** | Benefits will not be provided for any pre-existing condition – that is, a sickness or injury for which you received treatment during the preceding 12 months. | |

## LONG-TERM DISABILITY

Long-Term Disability (LTD) benefits replace a portion of your base monthly salary after you have been disabled for six months or more. UMass Memorial automatically provides a Base LTD benefit equal to 55% of your base monthly salary. If you wish, you can elect to increase your benefit to 66-⅔% by participating in the Supplemental LTD plan.

### Eligibility

You are eligible to participate in the LTD plan if you occupy a position budgeted for at least 20 hours per

week. Your coverage becomes effective on the first day of the month after your date of hire or the first of the month following your transfer into a benefits eligible position. There are specific limitations on pre-existing conditions and actively at work requirements.

## Enrollment

**When to Provide Evidence of Insurability (EOI)**

If you elect LTD coverage after your initial eligibility period, you must submit a completed EOI form to UNUM. EOI forms are available by calling the HR Call Center at 1-508-334-1999.

Once you are eligible, you are automatically enrolled in the Base LTD plan. You may elect coverage under the Supplemental LTD plan within 30 days of becoming eligible. If you don't elect coverage when you are first eligible, you may enroll during any future enrollment period (and must complete an Evidence of Insurability (EOI) form). During enrollment, you are free to elect or drop Supplemental LTD coverage for the upcoming year.

## Paying for Coverage

UMass Memorial automatically pays the full cost of the Base LTD plan. If you elect coverage under the Supplemental LTD plan, premiums will be deducted weekly.

## How Benefits Are Determined

**Base Monthly Salary Means . . .**

Your gross monthly income (before taxes and pre-tax deductions are withheld) at the time your disability began. It excludes overtime, bonus and shift differential.

The LTD plan is designed to provide you with continuing income if you remain disabled for more than six months. Your monthly benefit will equal 55% of your base monthly salary (or 66-⅔% if you elect supplemental coverage).

For the purposes of this plan, your *base monthly salary* means your base pay each month (not including bonuses, overtime pay and other extra compensation) before taxes and pre-tax contributions are withheld.

Benefits are paid monthly. However, benefits may be reduced by payments you receive from other sources such as Social Security and Workers' Compensation. See *Coordination with Other Income and Disability Benefits* on page 8.

## LTD COVERAGE

| | Base LTD Plan | Supplemental LTD Plan |
|---|---|---|
| Benefit Amount | 55% of your base monthly salary, up to a maximum of $3,000 per month. | 66-⅔% of your base monthly salary, up to a maximum of $10,000 per month. |
| When Benefits Begin | After you have been disabled for 180 days. | |
| Your Share of the Cost | None. UMass Memorial pays the full cost. | You pay an amount equal to your base monthly salary times $.00252. |
| How Disability is Defined | Unable to work at your own occupation for two years. After two years, unable to work at any occupation. | Unable to work at your own occupation for two years. After two years, unable to work at any occupation. |

### Definition of Disability

**To Receive A Benefit**

You must:

- Be unable to work for six months or longer (180 days)
- Require the regular care of a doctor
- Receive UNUM's approval for benefit payment

You are considered disabled if you are eligible for coverage and:

- **During the first 24 months of receiving LTD benefit payments (24 months under the Supplemental LTD)**, you are unable to perform your occupation due to sickness or injury.
- **After that time**, you are unable to perform any other occupation for which you are reasonably suited based on your education, training or prior job experience.

### How Long-Term Benefits Are Paid

Your long-term disability benefits will continue as long as your disability continues, up to certain time limits based on your age at the time your disability began (which is summarized in the following chart).

| If you Were This Age When You Became Disabled . . . | Your Benefit Payments Continue . . . |
|---|---|
| Younger than age 60 | To age 65 |
| Age 60 | 60 months |
| Age 61 | 48 months |
| Age 62 | 42 months |
| Age 63 | 36 months |
| Age 64 | 30 months |
| Age 65 | 24 months |
| Age 66 | 21 months |
| Age 67 | 18 months |

| | |
|---|---|
| Age 68 | 15 months |
| Age 69 and older | 12 months |

### When Your Coverage Continues

Your coverage continues under certain circumstances when you are not working. These circumstances include any approved leave of absence (such as the 12-week leave required by the Federal and Medical Leave of Absence Act of 1993). This means that you return to work after an approved leave, your coverage will be reinstated (without your having to wait another six months).

### Coordination with Other Income and Disability Benefits

**Applying for Social Security**

Because your LTD benefit will be reduced by any benefit you are entitled to receive from Social Security, you should apply for Social Security benefits as soon as possible (ideally, no later than 90 days after becoming disabled).

An application for Social Security disability benefits is available at www.medicare.gov. Or you can call 1-800-772-1213.

You should be aware that the long-term disability benefits you receive from this plan will be coordinated with other income you may be eligible to receive.

These sources include amounts you are entitled to receive under:

- Social Security
- Workers' Compensation
- Any other group disability insurance plan and
- The UMass Memorial Health Care Pension Plan.

In this way, the maximum benefit you receive from all sources does not exceed 55% of your base monthly salary (or 66-⅔% if you elect Supplemental LTD coverage). These amounts are determined at the time you apply for benefits and may change while you are disabled (if the actual benefit you are receiving from another source changes).

If subtracting other sources of income from your maximum benefit reduces the amount you would be eligible to receive from this plan to zero, then you will receive the greater of:

- $100 or
- 10% of your LTD benefit amount.

## HOW TO APPLY FOR BENEFITS

If you and your doctor expect that your disability will last longer than six months, you should contact Human Resources about applying for long-term disability benefits. To receive benefits, both you and your physician need to complete a written LTD claim form and submit it to UNUM. Ideally, you should

submit your claim before you have received all of your short-term disability benefits (if not, then at least 90 days after your long-term disability begins, but no later than one year later).

Your claim must provide proof of your disability. In addition to showing that you are under the regular care of a doctor, if should include:

- The date the disability started
- The cause of the disability
- The amount of your base monthly salary
- How serious the disability is, including information about any restrictions or limitations that prevent you from performing your regular occupation and
- The name and address of any hospital or institutions where you received treatment (as well as the names of all attending doctors).

Your completed claim form should be sent to:

UNUM Life Insurance Company of America
P.O. Box 9500
Portland, ME 04104-5058

UNUM will generally approve or deny your claim within six weeks after your claim form and all necessary supporting materials have been received. If your claim is denied, you have the right to appeal. For time frames associated with claims and appeals, see page 13.

### If You Receive Overpayments

If any benefits you receive from other sources result in an overpayment from this plan, you will need to repay it. UNUM will determine the best way to recover this amount.

## RETURNING TO WORK

If you recover from your disability and are able to return to work, then UNUM may ask you to participate in a rehabilitation and Return to Work Assistance program. This program, designed to help you return to gainful employment, is based on your individual circumstances. It may include job placement service, education, retraining or coordination with your employer to accommodate your work site.

### If Your Disability Occurs Again

If you return to work for less than six months and you become disabled again because of the same or a related condition, your second disability will be treated as an extension of the first disability. This means your LTD benefit payments will resume immediately.

If you return to work for six months or more before becoming disabled again, you will need to satisfy the six-month waiting period before LTD benefit payments can begin.

### If You Are Disabled and Working

If you remain disabled but are able to resume work on a limited basis, you may be able to continue to receive LTD benefits.

- **During the first 12 months of benefit payments while you are working**, your monthly LTD benefit will not be reduced as long as your pay when added to your LTD benefit does not exceed your pre-disability income.
- **After 12 months of payments**, your LTD benefits may be reduced if your pay exceeds a certain amount.

## BENEFIT EXCLUSIONS AND LIMITATIONS

The STD and LTD plans do not cover any disability resulting from:

- An act of war
- Intentionally self-inflicted injuries
- Active participation in a riot or
- A crime for which you have been convicted.

### Mental Health Benefit Limits

If you are disabled due to mental illness, your LTD benefit payments will be limited to 24 months, unless you meet one of the following conditions:

- If you are hospitalized at the time you receive your 24th monthly payment, LTD payments will continue while you remain in the hospital.
- If you are still disabled when you are discharged, monthly benefits will be paid for up to 90 days during your recovery.
- If you are re-admitted to the hospital during the 90-day recovery period (for at least 14 consecutive days), benefits will be paid while you are hospitalized and for another 90-day recovery period.

### Pre-Existing Condition Limits

The STD and LTD plans do not pay a benefit for any disability that is related to a pre-existing condition, unless the disability begins 12 or more months after you have been covered by the STD or LTD plan. A pre-existing condition is an illness or injury for which you received medication, treatment, consultation, care or services during the three months before your participation in this plan.

## WHEN BENEFIT PAYMENTS STOP

Benefits generally end when you are no longer considered disabled under the plan's definition or when you reach the maximum benefit period (as summarized on page 6). In addition, LTD benefits end on the earliest of the following dates:

- You or your doctor fail to provide proof of your disability if requested by UNUM
- You fail to participate in UNUM's Rehabilitation and Return to Work Assistance program
- You reside outside the United States for six months or more
- You are able to work on a part-time basis but you choose not to work or
- You die.

**Survivor Benefit**

If you die while receiving on LTD benefit, your spouse will receive a lump sum payment equal to three times your monthly benefit. If you are not married, payment will be made to your children. If you do not have any survivors, payment will be made to your estate.

**YOUR RIGHT TO APPEAL**

**Time Frame for Initial Claim Determination Made After January 1, 2003**

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the plan administrator will notify you of the adverse determination within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the plan administrator both determines the extension is

necessary due to matters beyond the control of the plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based
- The unresolved issues that prevent a decision on the claim
- The additional information needed to resolve those issues.

You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination is tolled (i.e., stopped) from the date the plan administrator sends you the extension notification until the date you respond to the request for additional information.

**If You Receive an Adverse Benefit Determination**

The plan administrator will provide you with a notification of any adverse benefit determination, which will include:

- The specific reason(s) for the adverse benefit determination
- Reference to the specific plan provisions on which the benefit determination is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary
- A description of the plan's appeal procedures and time limits applicable to such procedures
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determinations will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

**Procedures for Appealing an Adverse Benefit Determination**

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrate compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

- A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted by a named fiduciary of the plan that is neither the individual who made the adverse determination nor the person's subordinate
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.

The plan administrator must notify you of the plan's benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your request (unless the plan administrator determines that special circumstances require an extension of time). If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 45-day period. The notice

of the extension must indicate the special circumstances and the date by which the plan administrator expects to render the determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the plan administrator sends you the extension notification until the date you respond to the request for additional information.

The plan administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- Reference to the specific plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or notice that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the

adverse benefit determination will be provided free of charge upon request

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.